2026 EMPLOYEE BENEFITS GUIDE

NEW HIRES ENROLL WITHIN 31 DAYS

Superior

2026

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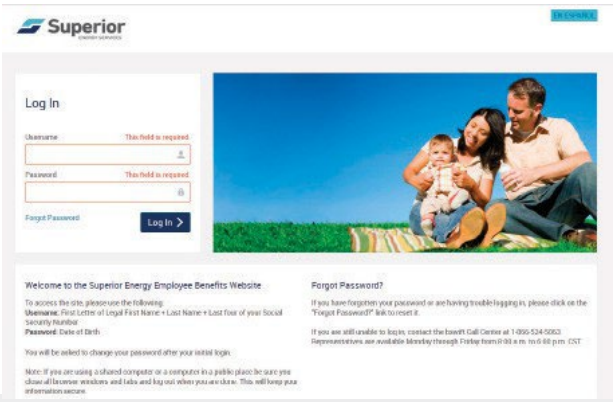
EMPLOYEE BENEFITS

At Superior, employee benefits are an integral part of our comprehensive compensation program. We are pleased to offer a robust package of benefits and programs for you and your eligible dependents. This booklet was created to provide you with an easy-to-read overview of your benefit options to help you make an informed decision. The coverage you choose during this period will remain effective until December 31, 2026. You will not be able to make changes until the next open enrollment, unless you experience a Qualifying Life Event.

YOUR GUIDE TO ONLINE ENROLLMENT

It's easy to enroll – here's how it works and what to expect!



1 Login to the Superior Benefits Website

You'll find all of the information you need about your benefits. If you want your current elections to remain the same, no action is required. However, we do encourage everyone to update their beneficiary online.

There are 3 ways to get to the Superior Benefits Website:

1. Go to **https://superiorbenefits.bswift.com** and login:
Username: First initial of **legal** first name, last name, last four of SSN (jsmith1234)
Password: Date of Birth (MMDDYYYY)

2. Download the **bswift benefits** mobile app from your app store and login using the following:
Company ID: *superiorbenefits*
Username: First initial of **legal** first name, last name, last four of SSN (jsmith1234)
If you've never logged in to the website:
Password: Same as your unique Superior Benefits Website password
You must first enter a unique password via the *superiobenefits.bswift.com* website before you will be able to login via the mobile app. If you have logged in and forgot your password, click on the **"Forgot Password"** link.

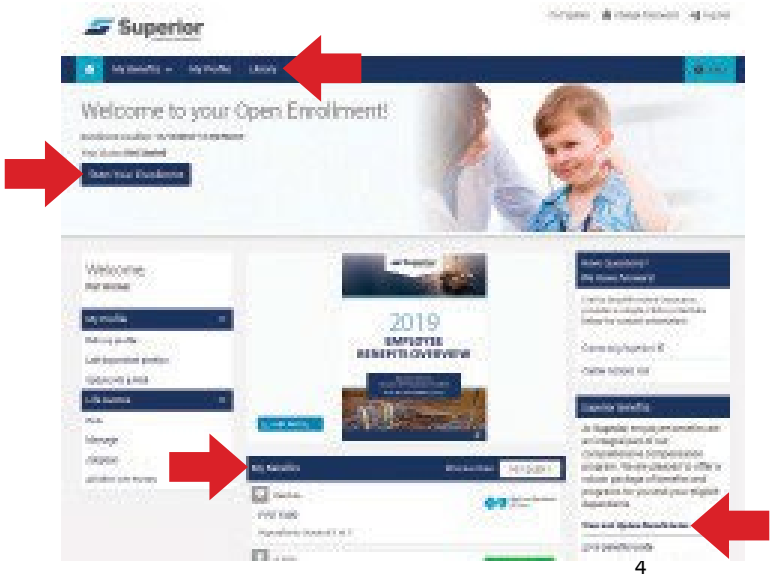
3. If you use a company assigned computer, you can log in by going to **www.superiorenergy.com** and clicking on the **"My Benefits"** link which will take you directly into the **Superior Benefits Website**.
If prompted to sign in:
Username: First initial of **legal** first name, last name, last four of SSN (jsmith1234)
If you've never logged in to the website:
Password: Date of Birth (MMDDYYYY)
If you've logged in and forgot your password, click on the **"Forgot Password"** link.

If you want to **review your current benefits** without making other elections or changes, you will find a listing under **My Benefits** on the Superior Benefits Website Home Page. You may also **update your beneficiary** from the Superior Benefits Website Home Page at any time. Just click on **"View and Update Beneficiaries"**.

Access all benefits forms and other benefits materials by clicking **"Library"** at the top of the home page.

2 Start your enrollment

Click on the **"Start Your Enrollment"** button to begin enrolling in your benefits.

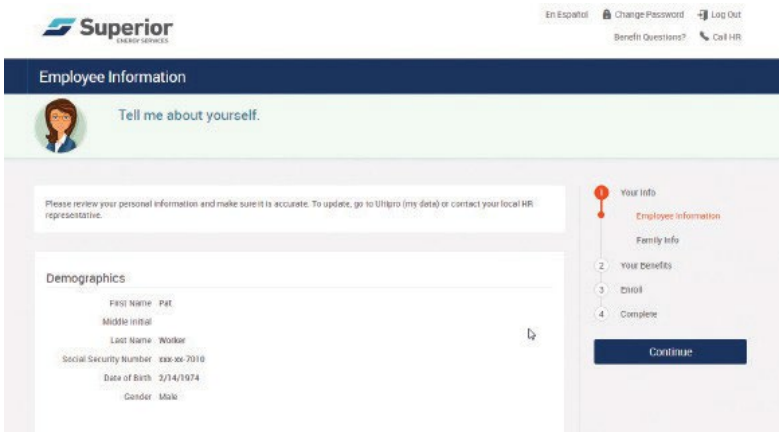


3 Review your personal information

Verify that all of your personal information is correct, including your address, telephone number and email address.

To make corrections, log in to Ultipro (My Data). However, you can continue with your enrollment before changes are made.

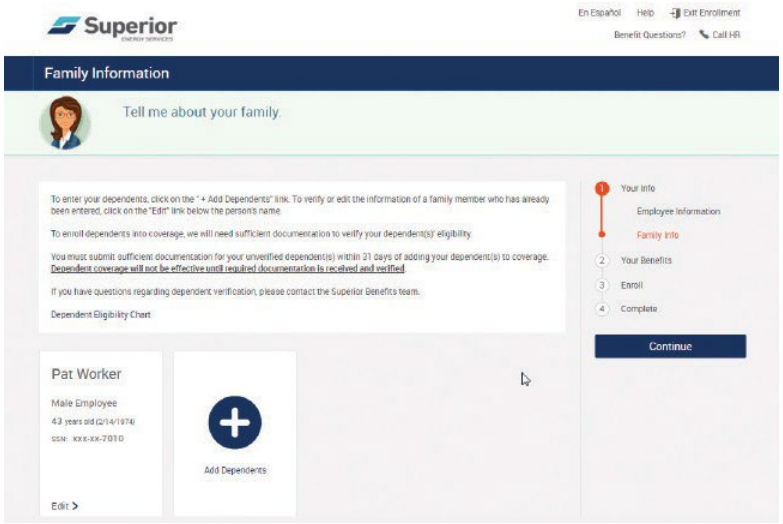
To consent to receiving Form 1095-C electronically, scroll to the bottom of the page, choose **"Go Paperless! I consent to receive my Form 1095-C electronically."**.



4 Enter your dependent information

Verify current dependents and add any eligible dependent information.

You must verify all newly added dependents within 31 days of hire or life event by providing documentation.

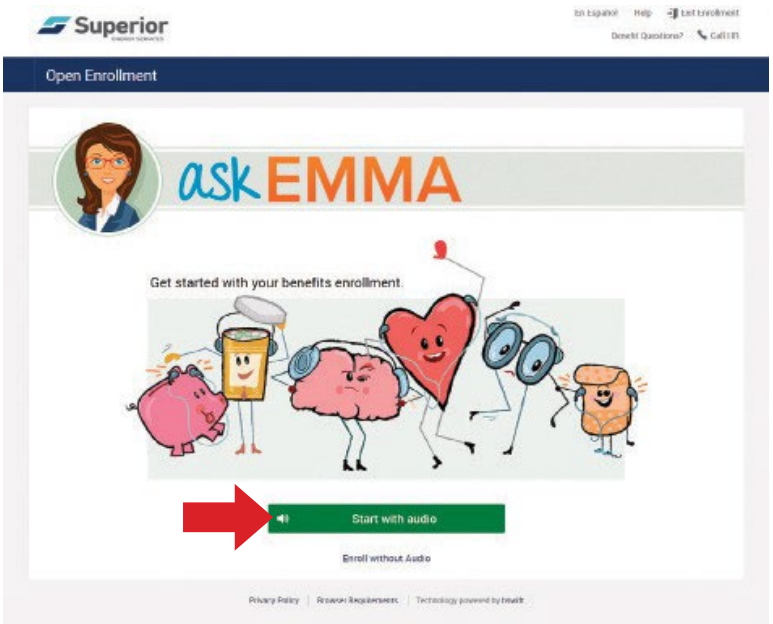


5 Ask Emma

Ask Emma is an interactive decision support tool. Emma helps you make more informed and personalized decisions across the benefits offerings through an engaging experience. Emma takes the guesswork out of choosing your benefits by helping with personalized cost comparisons based on your health needs.

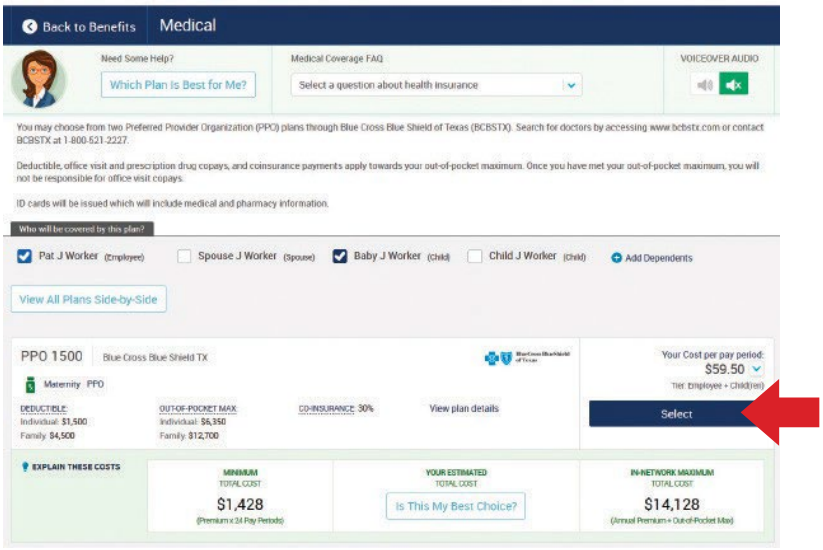
Click "with Audio" to hear Emma walk you through enrollment.

Otherwise, click "without audio" .



6 View your plan options

To make elections without using Ask Emma click “Select”.

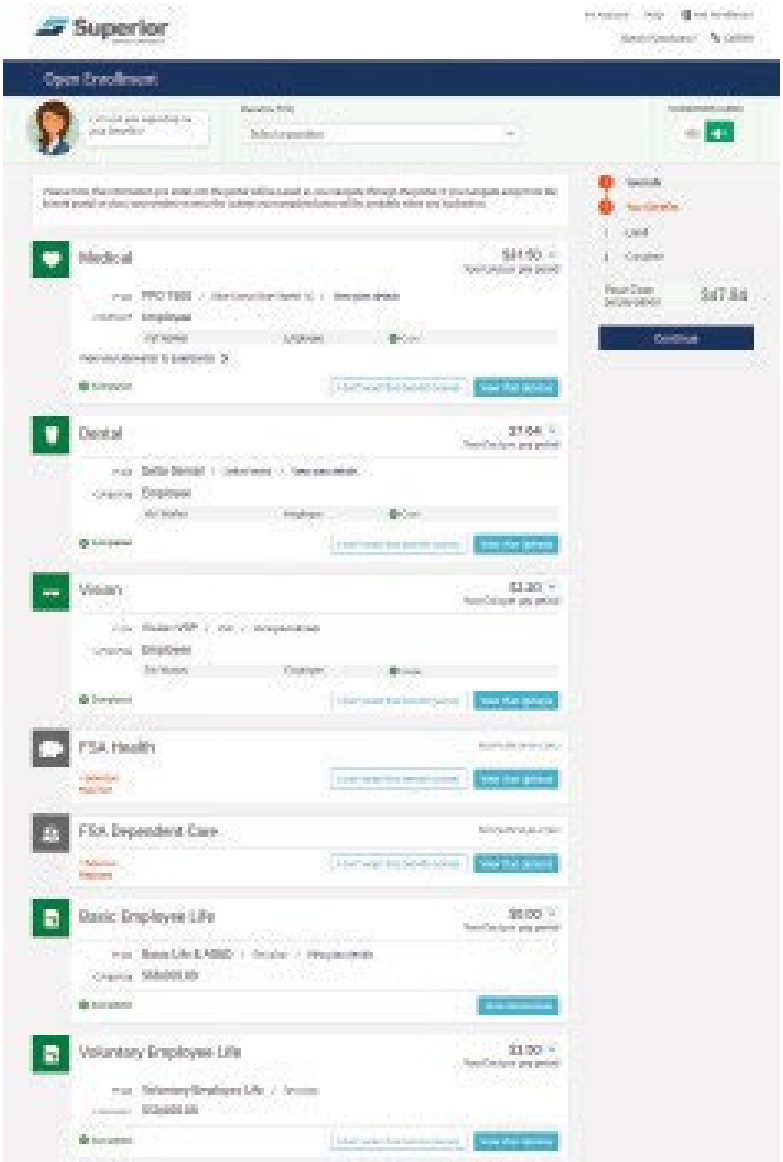


7 Choose your benefits

Click “View Plan Options” and select who you would like to cover for each plan.

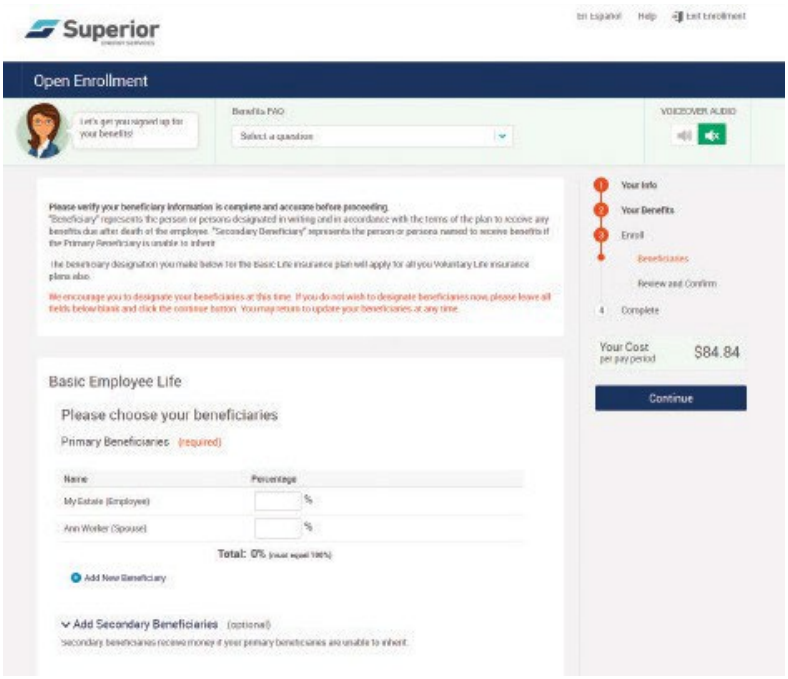
Required Field: If you are enrolling or making changes, you must waive or enroll in the Flexible Spending Accounts (FSA) plans.

Review your employer provided benefits. No elections are required for these plans.



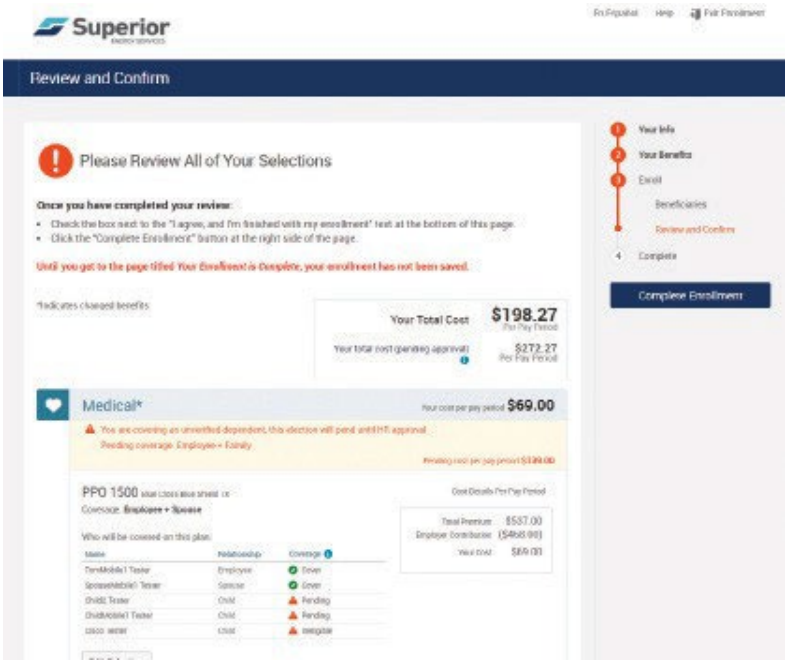
8 Assign your beneficiaries

Designate your life insurance beneficiaries.



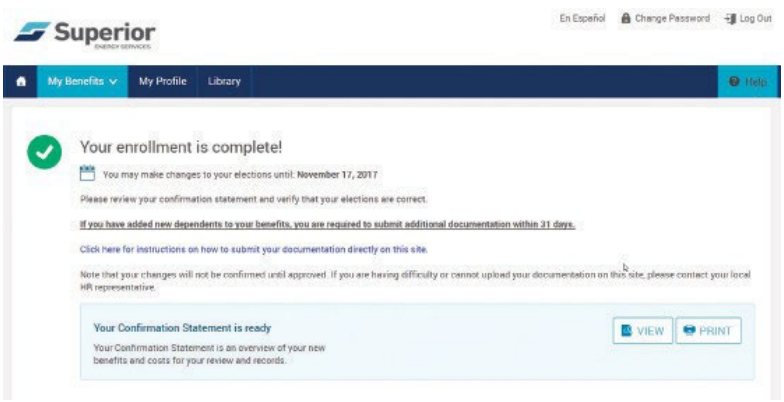
9 Confirm your selections

Take another moment to look over your selections and make any necessary changes.



10 View your confirmation statement

You can save, print, or email your information, and you'll have a record of your total costs. You can make changes until your enrollment period ends.



WHO IS ELIGIBLE

All full-time employees regularly scheduled to work at least 30 hours per week are eligible for benefits. Employees are eligible for the Medical, Dental, and Vision plans on the first of the month following date of hire. You have 31 days from your date of hire to enroll in coverage. Employees are eligible for Disability coverages beginning on the first day of the sixth month of employment. Eligible dependents may also be enrolled for coverage. Eligible dependents include:

- Your legal Spouse
- Your child under age 26 including your natural child, legally adopted child, or step-child
- Your child of any age who is medically certified as disabled and dependent on you for support and maintenance. Complete and submit the BCBSTX - Disabled Dependent Form located on the Superior Benefits Website Library
- Your grandchild who, at the time when application for coverage is made, is your dependent for federal income tax purposes and to whom you are a legal guardian
- A child you are required to cover under a qualified medical child support order
- A child who is dependent upon you for more than half of their support (as defined by the Internal Revenue Code of
- the United States), and to whom you are a legal guardian

Dependent Verification

Please note that Superior requires that all employees enrolling new dependents provide documentation of eligibility within 31 days of hire or life event. Superior reserves the right to request documentation to substantiate the eligibility of covered dependents at any time.

Some examples of acceptable dependent documentation include:

- Marriage License
- Birth Certificate
- Adoption Paper
- Tax Filings

Keep your dependent documentation easily accessible because random dependent audits will be conducted throughout the year. If you are unable to provide documentation when requested, your dependents' coverage may be terminated.

QUALIFYING LIFE EVENTS

During the year you only have one opportunity to enroll or make changes to your benefits for the following year, during Open Enrollment. The benefits you choose at hire or during Open Enrollment must stay in place until December 31st. However, if you experience a Qualifying Life Event, you will have the opportunity to make changes to your benefits that are due to and consistent with the change in family status outside of the Open Enrollment period. Qualifying Life Events include (but are not limited to):

- Marriage, divorce, or legal separation
- Gain or loss of an eligible family member for reasons such as a spouse gaining or losing coverage, birth, adoption, court order, death or reaching the dependent child age limit
- You or your dependent becomes entitled to, or loses, Medicare or Medicaid coverage

You have 60 days after the birth or adoption of a child to add the child to your coverage. Notifying BCBSTX is not sufficient, you must add the child to your coverage through the online employee benefits website.

If you experience a Qualifying Life Event, you must make your elections online through the Superior Benefits Website within 31 days of that Qualifying Life Event (60 days for a birth or adoption). You must provide dependent documentation for any dependents you add to your coverage.

You may also need to provide supporting documentation for the life event. If you do not provide the necessary documentation within 31 days of the event (60 days for a birth or adoption), your coverage will remain unchanged for the remainder of the calendar year.

Qualified status changes become effective on the first of the month following the event except for birth or adoption which are effective on the date of the event.

BENEFITS AT A GLANCE

Superior Benefit	Enrollment Optional or Automatic	Coverage
Medical/Rx/Telehealth	Optional—You and Superior share the cost	Superior provides three different plans through BCBSTX including $750 and $1,500 PPO deductible options and a $1,750 High Deductible Health Plan with HSA.
Dental	Optional—You and Superior share the cost	Superior provides comprehensive dental coverage through Delta Dental. Employees have access to the Delta PPO network.
Vision	Optional—You pay the cost	Superior provides a vision plan through VSP.
Flexible Spending Account (FSA)	Optional—You pay the cost	Two separate accounts let you use pretax dollars to pay IRS-eligible out-of-pocket Healthcare and Dependent Care expenses.
Employee Assistance Program (EAP)	Automatic—Superior pays the cost	Superior pays for five face-to-face counseling services per year and for 24/7 phone counseling.
Basic Life/AD&D	Automatic—Superior pays the cost	Superior pays for a basic life benefit of 1.5 times base salary to a maximum of $500,000.
Voluntary Life	Optional—You pay the cost	You may elect coverage in $10,000 increments up to $500,000. Spouse and child life coverage is available.
Short-Term Disability	Automatic—Superior pays the cost	Employees are eligible for coverage on the first day of the sixth month of employment. STD provides coverage in the event you cannot work due to a covered accident or illness.
Long-Term Disability	Automatic—Superior pays the cost	Employees are eligible for coverage on the first day of the sixth month of employment. LTD provides coverage in the event you cannot work due to a covered accident or illness.
401(k)	Optional—You pay the cost	Superior matches 100% of the first 4% of your contributions.

2026 EMPLOYEE CONTRIBUTIONS

	2026 Per Pay Period Rates (24 Deductions)				
	Medical			Dental	Vision
Coverage Tier	PPO 750	PPO 1500	HDHP 1750 w/HSA		
Employee	$121.00	$60.50	$44.00	$10.50	$2.25
Employee + Spouse	$299.00	$148.00	$129.50	$21.50	$4.51
Employee + Child(ren)	$288.00	$137.50	$121.00	$18.50	$4.83
Family	$454.50	$230.50	$202.00	$33.00	$7.71

VOLUNTARY LIFE EMPLOYEE CONTRIBUTIONS

Employee and Spouse Voluntary Life coverage can be elected in $10,000 increments. Child Life coverage is $10,000.

Employee and Spouse Voluntary Life Age Based Rates (per $1,000)	
Age Bands	Employee / Spouse*(per month)
<25	$0.069
25-29	$0.079
30-34	$0.109
35-39	$0.119
40-44	$0.139
45-49	$0.198
50-54	$0.297
55-59	$0.545
60-64	$0.792
65-69	$1.604
70+	$2.266

* Voluntary Spouse Life rate is based on the employee's age.

Employee or Spouse Voluntary Life Per Pay Period Cost Calculator:

To calculate Employee or Spouse Voluntary Life per pay period cost, follow the formula below.

$_____/ $1,000 = $_____x $_____= $_____x 12 months = $_____/ 24 pay periods = $_____

Elected Amount | Age Based Rate | Monthly Cost | Your Per Pay Period Cost

Child(ren) Voluntary Life Rate	
Monthly Rate	$1.00

MEDICAL PLAN OPTIONS

You may choose from two Preferred Provider Organizations (PPO) plans: The 750 and 1500 Deductible Options. With the PPO plans, you pay a copay for in-network office visits and a percentage of the cost for all other care until you reach the annual coinsurance maximum. You must meet a deductible before the plan pays its share of coinsurance. All Copayments and Coinsurance amounts contribute to the out-of-pocket maximum. Once the individual and/or family out-of-pocket maximum is satisfied no additional copayment/ coinsurance will be required for the member and or family for the remainder of the benefit period.

Another option is the High Deductible Health Plan (HDHP). The HDHP is a health plan that combines a Health Savings Account (HSA) through Fidelity with traditional medical coverage. The HDHP provides medical coverage, and the HSA provides a tax-advantaged way to help pay for current medical expenses and save for future health care expenses. You pay for 100% of non-preventive care, including the cost for prescriptions, until you meet the annual deductible. Copays do not apply to this plan. If you cover any dependents, you must meet the entire family deductible before the plan begins paying for qualified medical or prescription drug expenses for individual family members. One family member, or all family members combined, can satisfy the deductible. The full family annual deductible of $3,500 must be met before the plan begins to pay benefits. Once the family deductible is met, the plan will pay 80% of qualified expenses until the in-network out-of-pocket maximum ($8,150 individual/$10,000 family) is met. The plan covers 100% of the qualified charges for the remainder of the plan year. The full family out-of-pocket maximum must be met before the plan will pay 100%. All plans are administered through Blue Cross Blue Shield of Texas (BCBSTX). Search for doctors by accessing www.bcbstx.com or contact BCBSTX at 1-800-521-2227. An HSA is an individual account used in conjunction with the High Deductible Health Plan to cover qualified out-of-pocket medical expenses on a tax-advantaged basis. Your HSA belongs entirely to you and can be used to pay for both current and future qualified medical expenses for you and your eligible dependents. You can contribute to your account, withdraw contributions to pay for current qualified medical expenses, and potentially grow your account on a tax-free basis by investing your savings in a wide array of investment options. Your HSA allows you to pay for qualified health care expenses, including your deductible, with tax-free dollars that you set aside each pay period.

To qualify for an HSA:

- You must be enrolled in a qualified HDHP
- You cannot be covered by other health insurance
- You cannot be claimed as a dependent on someone else's tax return
- You cannot be enrolled in Medicare
- **If you elect to contribute to an HSA for 2026 and you currently have a Healthcare FSA in 2025:** It is an Internal Revenue Service (IRS) regulation that if you or your spouse are currently enrolled in a Healthcare FSA, you MUST use all funds in the FSA by December 31st in order to be able to start contributing to an HSA on January 1st. If you choose to wait and use the funds during the 2 ½ month grace period, you must wait until April 1, 2026 to contribute to an HSA.

An HSA is one of the few savings vehicles that offers a triple tax advantage:

1. Tax-Free Contributions: You can make contributions to your HSA on a pre-tax basis
2. Tax-Free Earnings: Your HSA grows tax-free. When you open your Fidelity HSA, a brokerage account, you can choose to invest in a wide variety of investment options depending on your investment objective, time horizon, and risk tolerance. Any interest or investment earnings on your account are not taxed.
3. Tax-Free Distributions: You do not pay taxes on money you withdraw, provided you spend that money on eligible health care expenses.

The HSA is administered through Fidelity. You can contact them at 1-800-835-5095.

MEDICAL PLAN OPTIONS

Benefits	PPO 750	PPO 1500	HDHP 1750 w/ HSA
Deductible (In/Out-of-Network)			
Individual	$750/$2,250	$1,500/$4,500	$1,750/$5,250
Family	$2,250/$6,750	$4,500/$13,500	$3,500/$10,500
Out of Pocket Maximum (In/Out-of-Network - Includes Deductibles, Medical/Rx Copays, and Coinsurance)			
Individual	$3,500/$7,750	$6,350/$14,500	$5,000/$10,000
Family	$10,500/$23,250	$12,700/$43,500	$10,000*/$20,000
Coinsurance	80%/50%	70%/50%	80%/50%
Office Visit (Coinsurance percentages are after deductible except for In-Network Preventive Care)			
Office Visit (In person or virtual)	$30 copay/50%	$40 copay/50%	80%/50%
Specialist	$40 copay/50%	$50 copay/50%	80%/50%
Urgent Care	$50 copay/50%	$60 copay/50%	80%/50%
Preventive Care	100%/50%	100%/50%	100%/50%
Other Facility (Coinsurance percentages are after deductible)			
Inpatient	80%/$200 per admission deductible, then 50%	70%/$200 per admission deductible, then 50%	80%/50%
Outpatient	80%/50%	70%/50%	80%/50%
Emergency Room	80% after $250 copay	70% after $250 copay	80%/50%
Virtual Visits Powered by MDLive			
Telehealth	$10 copay	$10 copay	80% after deductible
Rx Coverage	**PPO 750**	**PPO 1500**	**HDHP 1750 w/ HSA**
Generic	$10		$10 after deductible
Preferred Brand	$40		$40 after deductible
Non-Preferred Brand	$75		$75 after deductible
Mail Order (90-day)			
Generic	$20		$20 after deductible
Preferred Brand	$80		$80 after deductible
Non-Preferred Brand	$150		$150 after deductible
Specialty Rx			
Generic	$75		$75 after deductible
Preferred Brand	$75		$75 after deductible
Non-Preferred Brand	$150		$150 after deductible

* $8,150 individual maximum

PRESCRIPTION DRUG PLAN

All of the Blue Cross Blue Shield of Texas medical plans include coverage for prescription drugs through CVS Caremark. The network includes most retail pharmacies, such as, CVS, Walgreens and Target. You may fill your prescriptions at participating retail pharmacies or through the mail order service.

Retail Pharmacy

When you present your medical plan ID card at a participating pharmacy, you will be charged a copay based on the type of prescription you receive. Keep in mind that generic drugs cost significantly less than their brand name counterparts, yet they can be equally effective. 90 day prescriptions can be filled at CVS retail pharmacies for only two copays.

Mail Order

If you are taking a maintenance medication for birth control or for conditions such as high blood pressure, asthma, or diabetes, you will save time if you utilize the mail-order service. CVS Caremark Mail Service Pharmacy provides prescription drug mail service. For your convenience, your prescriber can telephone or fax the prescription directly to CVS Caremark Mail Service Pharmacy for all medications except controlled substances.

Prior Authorization

As a safety and cost saving measure, certain medications will require review and approval before the medication can be covered by the plan. For example, prior authorization will now be required for anabolic steroids, non-preferred insulin, doxycycline, and some specialty medications. If your medication is part of the prior authorization program, your doctor will need to submit a request for coverage, which is available at **www.caremark.com**. Doctors may visit the website or call **1-800-294-5979** for more information.

CVS Caremark Specialty Prescriptions

You will need to use CVS Caremark Specialty Pharmacy to get coverage for all specialty medications. Specialty medications are defined as those used to treat complex medical conditions such as multiple sclerosis, hepatitis C, and cancer. These medications are typically high-cost, self-injected, and some may come in a pill form.

CVS Caremark Specialty Pharmacy will deliver these medications where and when you need them. Injection supplies (syringes, disposal containers, etc.) are included at no extra cost.

CVS Caremark Specialty Pharmacy wants to help you achieve the best results from your medication therapy. You can receive personalized support by telephone at **1-800-237-2767**.

PrudentRx Copay Program

The PrudentRx Copay Program allows you to get covered specialty medications that are on the Exclusive Specialty Drug List for $0. If you are prescribed an eligible drug, your pharmacist will advise you to register for the program by calling PrudentRx at **1-800-578-4403.**

CVS Formulary

Both brand-name and generic drugs are on the CVS Caremark Advance Control Formulary list and are offered at the lowest cost under your medical plan. The formulary list is always available for your review on the Caremark.com website. Medicines not on the list cost more, and you may be charged the full price if you continue using them. Check the list from time to time as you may have new drug options that will cost you less than your current drug.

Contacts

Caremark Customer Care
1-866-246-6977

CVS Caremark
Mail Service Pharmacy
1-866-246-6977

CVS Caremark
Specialty Pharmacy
1-800-237-2767

CVS Caremark
Prior Authorization
1-800-294-5979

Website
www.caremark.com

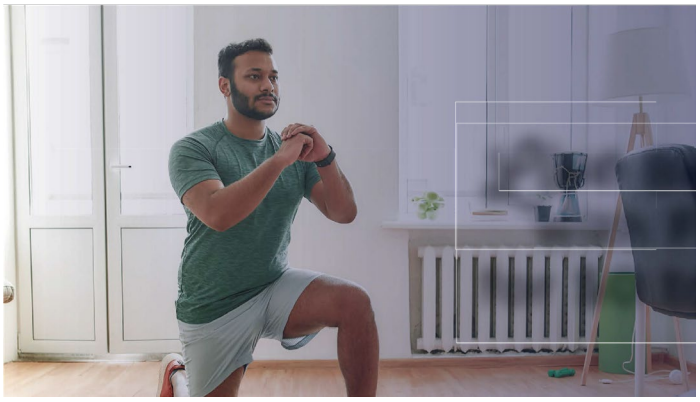
FLEX

Powered by AIRROSTI

Introducing Airrosti Flex!

Join Airrosti Flex for exercise therapy without leaving home. No copays. No office visits. Get relief for acute and chronic back and joint pain in just 10 minutes a day. Move Better. Feel Better. No Cost to You!

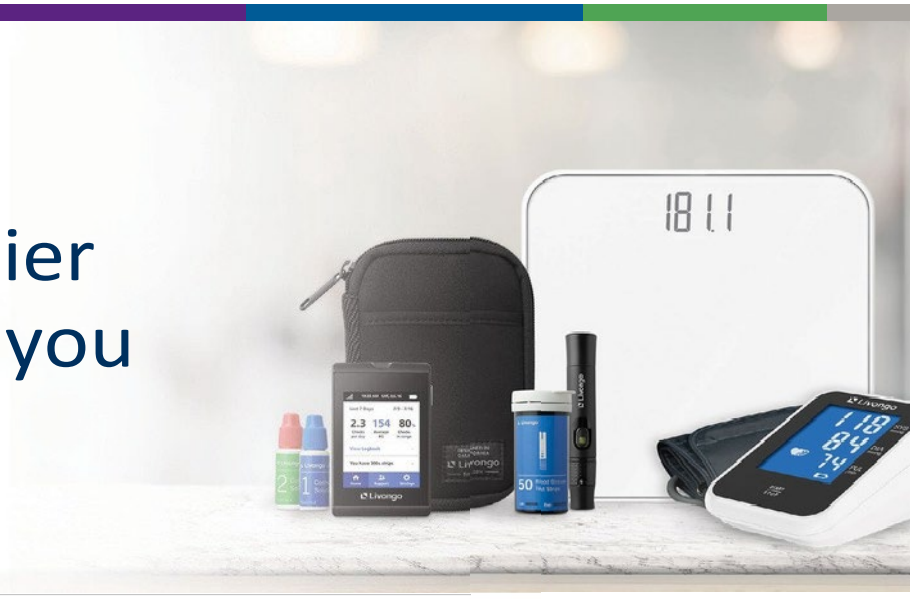
Airrosti Flex is only available to medical plan members and their covered dependents.



Scan the QR code or visit flexbyairrosti.com to learn more and enroll today for $0!

Livongo by Teladoc Health

Livongo means Living healthier at no cost to you



$0 cost to you

An advanced blood glucose meter and blood pressure monitor, plus the support you need

Diabetes Management
Connected meter
Unlimited strips and lancets

Hypertension Management
Connected monitor
One-on-one coaching

Livongo Healthy Living and Diabetes Prevention
Connected scale
Expert guidance

…And more programs!
Health experts
Personalized plans

Get started

Text **"GO SUPERIORENERGY"** to 85240 to learn more and join
You can also join by visiting **Go.Livongo.com/SUPERIORENERGY/register**
or call **800-945-4355** and use registration code: **SUPERIORENERGY**

VIRTUAL VISITS POWERED BY MDLIVE

All medical plan members and their covered dependents will have access to telehealth services through **Virtual Visits powered by MDLive**, a provider partner of Blue Cross Blue Shield of Texas. Telehealth services offer a cost effective and convenient alternative to emergency room or office visits for nonemergency health care and behavioral health needs. Telehealth services are available anytime, anywhere, from most U.S. locations.

Some advantages of telehealth are:

- $10 copay that can be charged to a debit or credit card if you are enrolled in the 750 or 1500 PPO plan. If you are enrolled in the 1750 High Deductible Plan, you will pay 20% of the reduced fee after the deductible;
- Access to Board certified doctors 24 hours a day, seven days a week, 365 days a year, by phone, or by secure video session for behavioral health (in certain areas for medical);
- Easy diagnosis of nonemergency symptoms, with the doctor able to prescribe medications and send the prescription to the pharmacy of your choice;
- Multi-lingual and TDD enabled services;

Behavioral Health Services Include:

- Diagnostic Assessments
- Ongoing counseling
- E-prescibing
- Ongoing medication management
- Care coordination

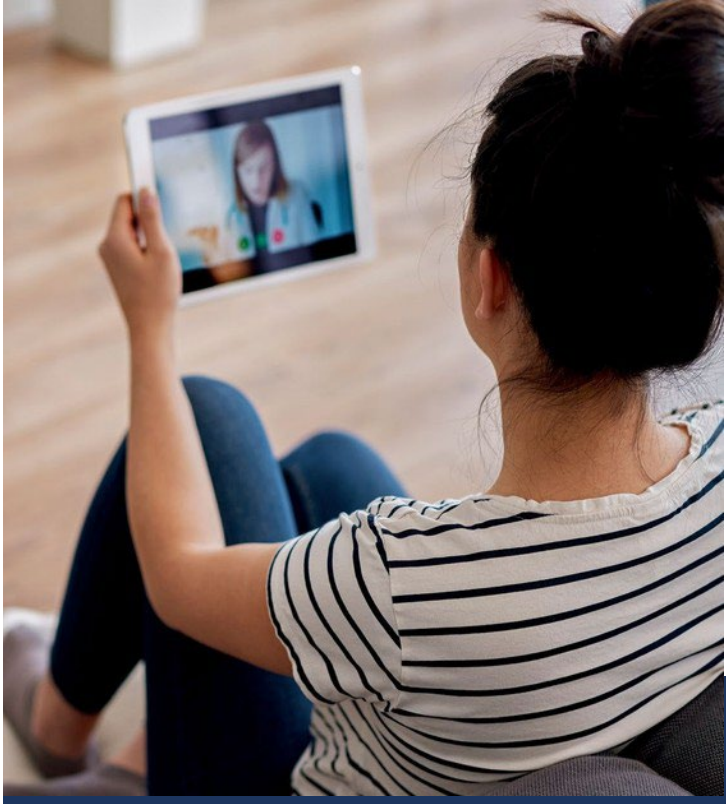
How To Access Care:

Once you activate your Virtual Visits account, you will have instant access to the services using one of the following methods:

- Online at mdlive.com
- By calling (888) 680-8646
- Download the MDLive mobile app from your app store.

A Little About Virtual Visits Doctors:

- Every doctor is state licensed and 100% Board Certified.
- Each doctor is trained in communicating with and diagnosing patients over the phone and via online video.
- Doctors average 15 years of experience in internal medicine, family practice, emergency medicine and pediatrics.



Telehealth services can address conditions such as:

Adult Care:

- Acne
- Joint Aches & Pains
- Allergies
- Nausea & Vomiting
- Bronchitis
- Pink Eye
- Cold & Flu
- Rashes
- Fever
- Sinus Infection
- Gout
- Sore Throat
- Headache
- Sunburn
- Infections
- Urinary Tract Infection

Pediatric Care:

- Cold & Flu
- Fever
- Constipation
- Nausea & Vomiting
- Earache
- Pink Eye

Behavioral Health:

- Marital Problems
- Depression & Anxiety
- Child Behavior & Learning issues
- Coping with Loss and Grief
- Financial Hardship
- Stresses & Challenges of Everyday Life

BCBSTX WELLNESS PROGRAMS FOR COVERED MEMBERS

PREVENTIVE CARE

Preventive care is very important for adults and children. By making smart health choices, women and men can boost their own health and well-being. Below is a list of services covered at no cost to you and any covered dependents if you visit an In-Network provider:

- An annual checkup
- Age and gender specific health screenings, including cholesterol, blood pressure, blood sugar and weight
- Routine immunizations based on your age, stage of life and health status including the annual flu shot

Did you know disclosure of aches and pains at a wellness visit could cause you to be responsible for a copay?

ProtectMyID® FROM EXPERIAN

- Safeguard Your Identity for a Brighter Future
- Get Daily Monitoring and Timely Alerts
- U.S. Based Fraud Team
- $1Million Identity Theft Insurance

Log into your BAM account at BCBSTX.com.

If you do not have a BAM account, you can register in three easy steps:

a) Go to BCBSTX.com/member

b) Click Register Now

c) Use the information on your BCBSTX ID card to complete the registration process.

DON'T GET THE FLU. DON'T SPREAD THE FLU. GET VACCINATED!

By visiting a participating provider, you can get a free flu vaccine. Choose from one of the options below:

- Visit Retail Pharmacies - Most large retail pharmacies such as CVS and Walgreens administer flu shots. Please confirm with the pharmacy, prior to obtaining a flu vaccination, that they participate in the flu vaccine program.
- Visit your In-Network Physician
- Out-Of-Network - Costs Vary

FITNESS PROGRAM

With the Fitness Program, members and their covered dependents (age 18 and older) are eligible to participate and receive a membership that allows them access to fitness centers nationwide.

- Join for as low as $19 per member per month
- Online fitness center locator
- Large network of fitness centers

To enroll call 1-888-762-2583 or log in to Blue Access for Members at bcbstx.com/member.

NURSELINE

Provides around-the-clock telephone access to registered nurses who can offer assistance and answer questions on a variety of health topics.

Call 1-800-581-0368

CONNECT WITH A WELLNESS COACH

WELLNESS COACH - Once members enroll in the tobacco cessation or Weight Management Program, they will be assigned a Wellness Coach who:

- Reviews symptoms and problems
- Provides personal assistance with goal setting, resource education, tips and periodic progress checkups
- Assesses commitment level
- Establishes a follow-up call schedule

WEIGHT MANAGEMENT - Get guidance and support for healthy eating habits and weight loss. Set goals, create action plans, and get coaching to stay motivated.

TOBACCO CESSATION - Enroll through BCBSTX OnLife Health program and receive smoking cessation prescription drugs at no cost.

- Self-directed online courses
- Tobacco cessation resources to help you become tobacco and nicotine free
- To qualify for this benefit you must enroll in the tobacco cessation counseling prior to filling your prescriptions.

To access the Weight Management and Tobacco Cessation Programs, call 1-877-806-9380, to speak to a wellness coach.

SPECIAL BEGINNINGS

The program supports mothers from early pregnancy until six weeks after delivery through: pregnancy risk factor identification, educational materials, personal telephone contact, and assistance in managing high risk conditions. You must enroll prior to the 34th week of pregnancy.

To enroll call 1-888-421-7781

BLUE ACCESS FOR MEMBERS (BAM)

Well on Target program encourages members to take an active role in enriching their overall health and well-being.

This wellness solution is available on Blue Access for Members.

The program includes:

- Interactive online classes for individual wellness goals
- Health Assessment to measure health status
- The Life Points program

Visit *bcbstx.com/member/register* to register and log in to BAM.

DENTAL PLAN

Dental coverage is an important component of Superior's comprehensive benefit plan. Coverage is offered through Delta Dental. Participants have access to Delta's PPO network. In-network dentists have agreed to provide discounted services, will file claims, and will not balance bill. Out-of-network provider costs will be reimbursed based on reasonable and customary fees. This reimbursement may not cover the full cost of services. In these cases, you may be balance-billed for the amount exceeding the reimbursement.

	Delta Dental	
Dental Provisions	Network	Out-Of-Network
Annual Deductible[1]		
Individual	$50	
Family	$150	
Maximums		
Class I, II, III Combined Calendar Year Maximum	$2,000	
Class IV Lifetime Maximum	$2,000	
Services		
Class I—Diagnostic and Preventive—Includes Exams, X-rays, Cleanings, Fluoride, Sealants	100%	
Class II—Basic Restorative and Surgical—Includes Fillings, Extractions, Root Canals	80%	
Class III—Major Restorative and Prosthodontic Procedures—Includes Crowns, Bridges, Dentures, Implants	50%	
Class IV—Orthodontia—Children < 19 years of age	50%	
Out-of-Network Reimbursement	90th percentile of R&C	

[1]Deductible applies to Class II and III services

Contacts

Member Services

1-800-521-2651

Website

www.deltadentalins.com

VISION PLAN

Vision coverage is provided through Vision Service Plan (VSP). VSP provides an extensive network of vision optometrists and ophthalmologists. Eye care is essential to a person's health and well-being. Members receive benefits for many eye care services and products including eye exams, eyeglasses, and contact lenses.

	PPO	
Vision Provisions	Network	Out-Of-Network
Standard Exam (Every 12 months)	$10 copay	Up to $45 after $10 copay
Materials—Lenses (Every 12 months)		
Single	$25 copay	Up to $30 after $25 copay
Lined Bifocal	$25 copay	Up to $50 after $25 copay
Lined Trifocal	$25 copay	Up to $65 after $25 copay
Lenticular	$25 copay	Up to $100 after $25 copay
Materials—Frames (Every 12 months)	Up to $130 after $25 copay	Up to $70 after $25 copay
Contacts (Every 12 months) In lieu of eyeglasses	Up to $130 copay waived	Up to $105 copay waived
Contacts—Fitting and Evaluation	Up to $60 copay	Up to $105 copay waived
Contacts (Every 12 months) In lieu of eyeglasses	$25 copay	Up to $210 after $25 copay
Safety Eye Care1	$25 copay	Reduced reimbursement

[1]Limited to employees who require safety eyewear to perform the duties of their job.

Contacts

Member Services

1-800-877-7195

Website

www.vsp.com

NO ID CARD NECESSARY:

Employees use their social security number and date of birth when utilizing benefits.

BASIC LIFE AND AD&D COVERAGE

Superior provides full-time employees with a Basic Life/AD&D benefit. The benefit is 100% employer paid. Eligible employees are covered at 1.5 times annual base salary with a maximum of $500,000 and a minimum of $50,000. If you suffer a covered loss due to an accident, AD&D coverage pays you a portion of the full benefit, as specified in the policy.

Coverage amounts automatically reduce at ages 65 and 70. When you reach the specified age below, the amount of your Basic Life Insurance will be reduced to the applicable percentage.

Age	Percentage of available or in-force amount
65-69	65%
70+	50%

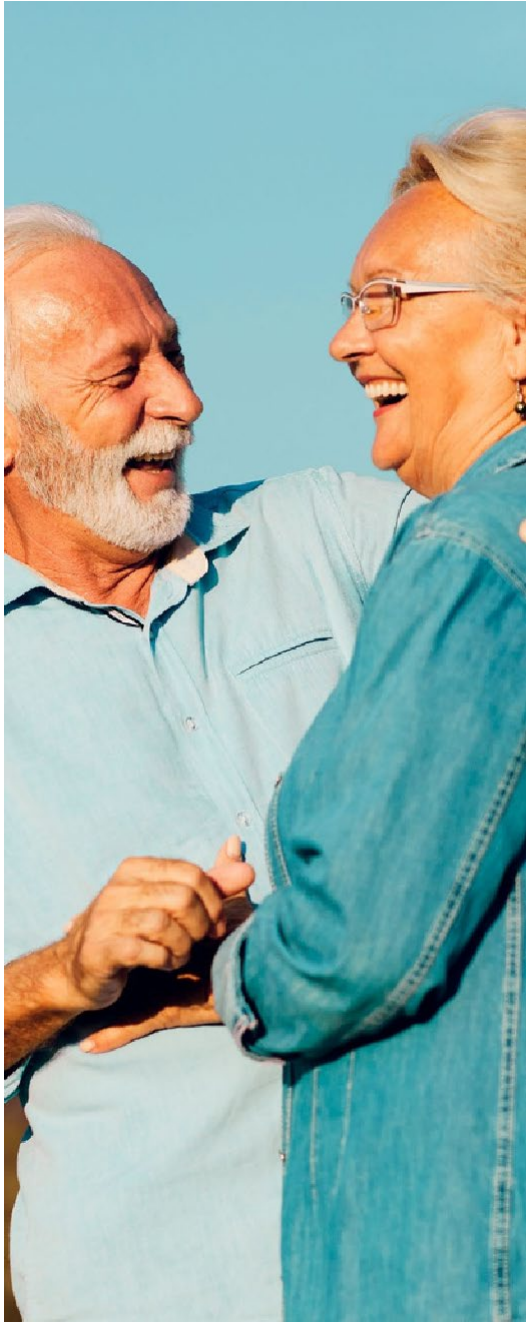
VOLUNTARY GROUP LIFE COVERAGE

You may purchase Voluntary Life coverage for yourself and your spouse in $10,000 increments. You may also elect coverage for your child(ren) in the amount of $10,000.

Guaranteed Issue Amounts

You may elect up to the guaranteed issue amounts within 31 days of becoming eligible. The guaranteed issue is the amount that can be elected without having to complete Evidence of Insurability (EOI). If you enroll or increase your coverage amount after your newly-eligible period, EOI will be required.

	Employee	Spouse	Child (up to age 26)
Minimum	$10,000	$10,000	$10,000
Maximum	$500,000	$500,000	$10,000
Guarantee Issue	$200,000	$50,000	$10,000



EMPLOYEE ASSISTANCE PROGRAM (EAP)

Superior has partnered with ComPsych to provide an Employee Assistance Program (EAP) for you and your dependents. This benefit is 100% employer paid. The EAP provides support and guidance for matters that range from personal issues you might be facing to providing information on everyday topics that affect your life. The free confidential service is available to you and your family members—24 hours a day, seven days a week. A toll-free phone line is staffed by experts trained to help you find the help you need, when you need it. You or a family member can call 1-800-272-7255 anytime, day or night. The EAP provides up to five (5) free counseling sessions per incident. The EAP is designed to assist with a wide array of issues, including work/life balance, stress, anxiety, depression, family issues, legal, and financial concerns.

Accessing the EAP is Easy

Counseling Services
1-800-272-7255

Website
www.guidanceresources.com

Company ID
COM589

SHORT-TERM DISABILITY AND LONG-TERM DISABILITY

Disability Insurance provides protection in the event you experience an injury or illness that prevents you from working. Superior pays the cost for both lines of coverage. Both plans are administered by Lincoln Financial Group. Pre-existing condition exclusions apply to STD and LTD coverage.

Short-Term Disability (STD)

Your benefits will begin on the eighth day following a nonoccupational accidental injury, sickness, or pregnancy. STD pays 75% of basic weekly pre-disability earnings (not including overtime, commissions, bonuses, and other extra compensation) up to a maximum of $2,300 a week, less deductible sources of income. The maximum benefit duration is 180 days.

Long-Term Disability (LTD)

LTD is available if your disability continues for more than 180 days. LTD benefits will be 60% of pre-disability earnings (not including overtime, commissions, bonuses, and other extra compensation) up to a maximum of $10,000 per month, less deductible sources of income. Benefits can last up to Social Security Normal Retirement Age.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Flexible Spending Accounts (FSAs) allow you to set aside money pretax to pay for qualified healthcare and dependent care expenses. FSA accounts are administered by WEX, formerly Discovery Benefits.

Paying for these expenses through a pretax spending account is like getting a discount on something you would have purchased at full price. You will be surprised at how quickly your savings add up.

Your contributions are deducted from your paycheck in equal amounts during the year. Because contributions are not subject to federal income tax, FICA tax, and, in most cases, state and local income taxes, you save money.

Each year, you decide how much you want to contribute to either or both accounts for the calendar year. The Healthcare FSA and Limited Purpose FSA accounts are capped at $3,300. You can still elect up to $5,000 for dependent care FSA (up to $2,500 if you are married and file separate tax returns). You will lose any FSA money you don't use within the eligible period. FSA dollars do not roll over from year to year.

Healthcare FSA Account

Eligible expenses include office visit and prescription drug copays, medical deductibles, and coinsurance. Qualified dental and vision expenses are also eligible, including eye exams, prescription eye wear, and orthodontic services.

Limited Purpose FSA

You must be enrolled in the HDHP 1750 with HSA medical option in order to be eligible for the Limited Purpose FSA, which is similar to a Healthcare FSA. However, the funds in the Limited Purpose FSA can only be used for dental and vision expenses such as copays, deductibles and coinsurance. This plan is compatible with the HSA, meaning you can enroll in both at the same time.

Dependent Care Account

Eligible dependent care expenses include licensed day care or elder care providers, before and after-school care through age 12, day camps, and care for a disabled dependent.

For a complete list of eligible expenses, go online to www.irs.gov/publications and find publications 502 and 503.

In order to get reimbursed, you can either submit a claim form accompanied by a receipt or use a debit card provided through WEX. Just swipe your card to pay for a covered item. The amount will be automatically deducted from your FSA account. Using the card eliminates paperwork and delays in being reimbursed. It is recommended that you retain your receipts in the event they are requested for documentation. Debit cards are automatically reloaded when you enroll each year. After four years, your debit card will expire and a new card will be sent to you approximately two months prior to the expiration date.

Filing a Claim

When you have an eligible expense, you submit a claim to WEX, the FSA administrator, for reimbursement. You must file your claims by the filing deadline. For all FSA accounts, you have until April 30 to file claims incurred in the prior year through March 15 of the current year. You have 90 days from the date your employment ends to file claims for eligible expenses that were incurred prior to your termination date.

Contacts

Member Services
1-866-451-3399

Website
www.wexinc.com

401(K) RETIREMENT PLAN

Superior's 401 (k) plan is one of the best ways you can save for retirement. Once enrolled, you save a percentage of your eligible pay, up to legal limits, toward your retirement. You can elect to contribute on a before-tax basis, Roth 401(k) basis, or a combination of both.

Superior matches 100% of every dollar you contribute, up to 4% of your eligible compensation per pay period. As a participant in the plan, you may contribution 1% to 75% and change, adjust, or stop contributions at any time.

Eligibility

You are eligible to enroll in the plan upon receipt of your first paycheck. However, your payroll deductions will begin on the most administratively feasible payroll check following your enrollment. If you are a rehire, you are eligible to enroll in the 401(k) plan by accessing your existing account and re-enrolling.

Investment Options

Superior's 401(k) plan allows you to choose from a variety of investment options. You decide which options best fit your long-term retirement needs. You will be able to review the summary plan description, fund performance history, fund prospectus, and access saving tools on the NetBenefits site. Remember that you — not the company — assume all investment risk.

Enrollment

You may enroll online by visiting **www.netbenefits.com** or by phone at 1-800-835-5095. In order to enroll online, the system will prompt new users to set up a USER ID and PASSWORD. If you have other accounts at Fidelity, you may use that login information for your Superior 401(k) enrollment.

To learn more about the plan review the **Summary Plan Description (SPD)**. The SPD is intended to provide a brief description of the current provisions of the Superior 401(k) Plan and is not intended to serve as a complete or final description of this plan. The plan document and trust agreement shall govern if there is a discrepancy between this SPD and the actual provisions of the plan.

Contacts

Fidelity Investment Retirement
1-800-835-5095

401(k) New Users - Easy Enroll (Smartphone, Tablet or Computer)
www.NetBenefits.com/Easy

Enroll/Access Your Account
www.netbenefits.com

ANNUAL REQUIRED NOTICES

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

The Superior Energy Benefits Service Center at 844-441-1401.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
SESI Holdings, Inc.	75-2379388
5. Employer address	6. Employer phone number
1001 Louisiana St., Suite 2900	713-654-2200

7. City	8. State	9. ZIP code
Houston	TX	77002

10. Who can we contact about employee health coverage at this job?	
11. Phone number (if different from above)	12. Email address
844-441-1401	superiorhr@superiorenergy.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☑ All employees. Eligible employees are:

    All full time employees are eligible. In accordance with the federal health care reform law, and solely for the purposes of determining eligibility under Superior's medical plan, "full time employee" means that you work, on average, at least 30 hours per week over the course of Superior's applicable measurement period. Superior uses a methodology to determine full time status for eligibility purposes that follows the guidelines issued by the federal government.

  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Legal spouse

    Dependent children under age 26
  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☑ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☑ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $88.00
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☑ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.
If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA - Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA - Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS - Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA- Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/HIBI
Customer Service: 1-855-692-6442

FLORIDA - Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA - Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA - Medicaid Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 1-800-457-4584 **IOWA - Medicaid**
Medicaid Website:
https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS - Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY - Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA - Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE - Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711

Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740

MASSACHUSETTS - Medicaid and CHIP Website:
https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA - Medicaid

Website:
https://mn.gov/dhs/people -we -ser ve/children-and-families/health-care/
health- care -programs/programs-and-ser vices/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI - Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA - Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA - Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA- Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance -premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY - Medicaid and CHIP

Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK - Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA - Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA - Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA - Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON - Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND - Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA - Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS - Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH - Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT- Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA - Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance -premium-payment-hipp -programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON - Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA - Medicaid

Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING - Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512. The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

SPECIAL ENROLLMENT NOTICE:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the birth or adoption, 31 days after the marriage.

Special enrollment rights also may exist in the following circumstances:

- You or your dependents experience a loss of eligibility for Medicaid or state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends
- You or your dependents become eligible for a state premium assistance subsidy through Medicaid or a CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for assistance.

To request special enrollment or obtain more information, contact Human Resource.

IMPORTANT NOTICE:
HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURE

Your Information. Your Rights. Our Responsibilities.

THIS NOTICE IS PROVIDED TO YOU ON BEHALF OF: SESI HOLDINGS, INC. GROUP BENEFIT PLAN. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this Notice, is:
Executive Director, Human Resources
SuperiorHR@superiorenergy.com
713-654-2200

Effective Date

The effective date of this Notice is: January 1, 2026

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Superior Energy Services Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The Superior Energy Services Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

Plan	Coinsurance	Deductible – Individual/Family:
$750 Deductible Plan	80%	$750/$2,250
$1,500 Deductible Plan	70%	$1,500/$4,500
$1,750 Deductible Plan	80%	$1,750/$3,500

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at 713-654-2200.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT NOTIC

Group health plans and health insurance issuers generally may not,under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

IMPORTANT NOTICE FROM SESI HOLDINGS, INC. ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Superior Energy Services, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Superior Energy Services, Inc. has determined that the current prescription drug coverage offered by Blue Cross Blue Shield of Texas is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays, and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Superior Energy Services, Inc. coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payment second.

For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone or Web address listed below.
If you do decide to join a Medicare drug plan and drop your current Superior Energy Services, Inc. coverage, be aware that you and your dependents will be able to get the coverage under the medical plans back in force at the next Open Enrollment period, assuming you meet eligibility requirements at that time.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current Superior Energy Services, Inc. coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October

For More Information About This Notice Or Your Current Prescription Drug Coverage:

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Superior Energy Services, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325- 0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	10/15/2025
Name of Entity/Sender:	Superior Energy Services, Inc.
Contact--Position/Office:	Manager, Group Benefits Address: 1001 Louisiana St.; Suite 2900 Houston, TX 77002
Phone Number:	713-654-2200

CONTACT INFORMATION

Coverage/Carrier	Phone Number	Website
Blue Cross Blue Shield of Texas Medical	Member Services: 1-800-521-2227 24-Hour Nurse Line Blue Care Connection: 1-866-412-8795	www.bcbstx.com/member
Caremark	1-866-246-6977	www.caremark.com
Virtual Visits Powered by MDLive	1-888-680-8646	www.mdlive.com
Delta Dental	1-800-521-2651	www.deltadentalins.com
Vision Service Plan	1-800-877-7195	www.vsp.com
WEX Flexible Spending Accounts	1-866-451-3399	www.wexinc.com
Lincoln Financial Group Short-Term Disability (STD)/ Long-Term Disability (LTD)	800-423-2765	www.LincolnFinancial.com
Securian Life and AD&D	1-800-815-7636	www.lifebenefits.com
ComPsych Employee Assistance Plan	1-800-272-7255	www.guidanceresources.com
Fidelity 401(k) Retirement Plan & Health Savings Account (HSA)	1-800-835-5095	www.netbenefits.com
Superior Energy Benefits Service Center	1-844-441-1401	www.superiorbenefits.bswift.com

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.