

2026



CONTRACTOR EMPLOYEE BENEFITS GUIDE

FOR A HEALTHY YOU



AVIATION PERSONNEL

HELPFUL RESOURCES

IMPORTANT CONTACTS

MEDICAL

United Healthcare
www.myuhc.com
866-633-2446

MEDICAL — MEC PLAN

Lucent
www.firsthealth.com
800-226-5116

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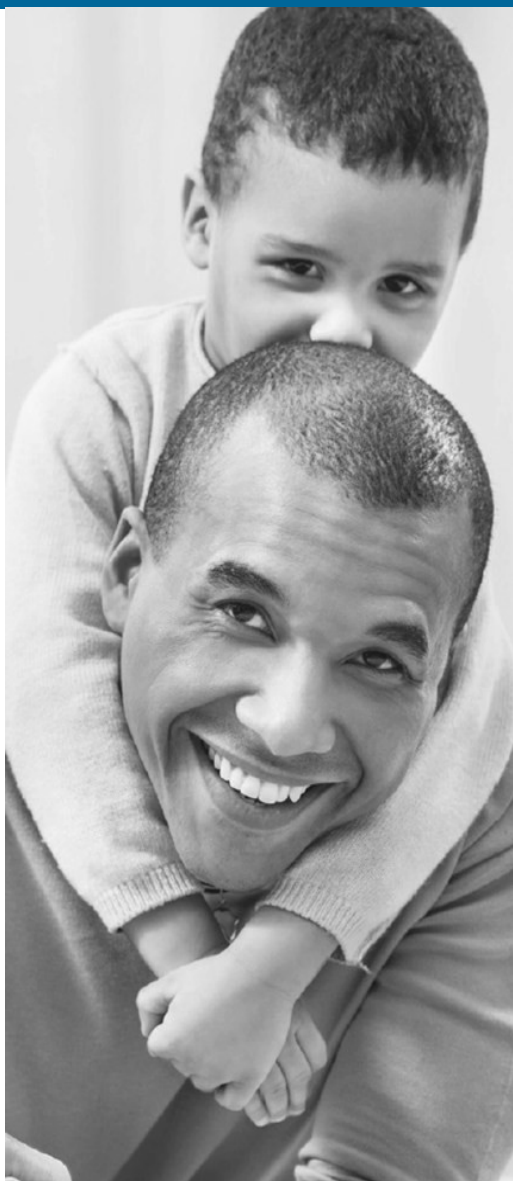
WELCOME

We are pleased to offer a full benefits package to you and your eligible dependents. At Aviation Personnel we offer a comprehensive benefits package intended to protect your well-being and financial health. This guide is your opportunity to learn more about the benefits available to you and your eligible dependents beginning **January 1, 2026**.

Each year during Open Enrollment, you have the opportunity to make changes to your benefit plans. The enrollment decisions you make this year will remain in effect through **December 31, 2026**. You may make changes to your benefit elections only when you have a Qualifying Life Event. After such an event, you can make changes to your health care coverage within 30 days; otherwise, you cannot make changes to your benefits coverage until the next Open Enrollment period.



If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 12 for more details.



2026 HIGHLIGHTS

- ◆ **Medical:** Medical coverage will remain with **United Healthcare**
- ◆ **MEC Plans:** MEC plan coverage will remain with **Lucent**.

ELIGIBILITY

WHO IS ELIGIBLE?

You are eligible for benefits if you are a regular, full-time employee working an average of 30 hours per week. **New hires**, your coverage is effective the first of the month following 60 days from date of employment. **Current employees**, your open enrollment will occur annually. You may also enroll eligible dependents for benefits coverage. The cost to you for dependent coverage will vary depending on the number of dependents you enroll in the plan and the particular plans you choose. When covering dependents, you must select the same plans for your dependents as you select for yourself.

If you terminate your employment, your medical benefits will terminate at midnight on the last day of the month of your termination date.

ELIGIBLE DEPENDENTS

- Your legal spouse.
- Children under the age of 26, regardless of student status, dependency or marital status.
- Children who are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return; coverage may continue past age 26.
- An unmarried child age 26 or older who is or becomes disabled and who is dependent upon you. A Statement of Dependent Eligibility must be completed and approved by the carriers.
- A child for whom healthcare coverage is required through a qualified medical child support order, other court order, or administrative order.

HOW TO ENROLL

Complete your new hire or annual enrollment form and submit to the Human Resources Department.

ANNUAL ENROLLMENT & QUALIFYING LIFE EVENTS

The choices you make during Annual Enrollment will be effective from **January 1, 2026 through December 31, 2026**. Once you elect your benefit options, they will remain in effect for the entire plan year until the following Open Enrollment. You may only change coverage during the plan year if you experience a **“Qualifying Event”** and you must notify Human Resources within 31 days of the event. Be prepared to provide documentation to support the Qualifying Event.

QUALIFYING LIFE EVENTS INCLUDE:

- Marriage, divorce, legal separation.
- Birth, adoption or placement for adoption of an eligible child.
- Death of a spouse or child.
- Change in your spouse's employment that affects benefits eligibility.
- Change in your child's eligibility for benefits (reaching the age limit).
- Change in residence that affects your eligibility for coverage.
- Significant change in coverage or cost in your, your spouse's or child's benefit plans.
- FMLA leave, COBRA event, Court Judgment or decree.
- Becoming eligible for Medicare or Medicaid.
- Receiving a Qualified Medical Child Support Order.

AVAILABILITY OF SUMMARY HEALTH INFORMATION

Your plan offers five health coverage options. To help you make an informed choice and compare your options, a Summary of Benefits and Coverage (SBC) is available summarizing important information about your health coverage in standard format. The SBC is available free of charge, by contacting Human Resources.

MEDICAL COVERAGE - *Lucent Health*

Deductible runs from January 1, 2026 - December 31, 2026

FIND A NETWORK PROVIDER

- Call (800) 226-5116
- Visit www.firsthealth.com

BENEFIT	Option 1 Base MEC	Option 2 Plus MEC
Network	FirstHealth	FirstHealth
Preventive Services—Adults	Covered 100%	Covered 100%
Preventive Services—Women	Covered 100%	Covered 100%
Preventive Services—Child(ren)	Covered 100%	Covered 100%
Hospital Indemnity Benefits	Reimbursement	Reimbursement
Outpatient Physician Office Visit	N/A	\$20 copay, 3/year
Emergency Room Benefit	N/A	N/A
Daily In-Hospital Benefit	N/A	N/A
Hospital Admission Benefit	N/A	N/A
Intensive Care Daily Benefit	N/A	N/A
Daily Prescription Drug Benefit	N/A	\$20 copay
Off the Job Accident Benefit	N/A	N/A
Critical Illness Benefit	N/A	N/A
Telemedicine—Teladoc	Included	Included

To locate a provider, visit www.firsthealth.com and select Locate a Provider. Click on “Locate a First Health Network Provider Now”.

MEDICAL RATES PER PAY PERIOD—WEEKLY		
COVERAGE LEVEL	Base MEC	Plus MEC
Employee Only	\$13.90	\$15.69
Employee + Spouse	\$25.21	\$29.77
Employee + Child(ren)	\$19.44	\$21.46
Employee + Family	\$30.98	\$34.15

MEDICAL COVERAGE - *Lucent Health*

Deductible runs from January 1, 2026 - December 31, 2026

FIND A NETWORK PROVIDER

- Call (800) 226-5116
- Visit www.firstthealth.com

BENEFIT	Option 3 Premium MEC	Option 4 Super MEC
Network	FirstHealth	FirstHealth
Preventive Services—Adults	Covered 100%	Covered 100%
Preventive Services—Women	Covered 100%	Covered 100%
Preventive Services—Child(ren)	Covered 100%	Covered 100%
Hospital Indemnity Benefits	Reimbursement	Reimbursement
Outpatient Physician Office Visit Emergency Room Benefit Daily In-Hospital Benefit Hospital Admission Benefit Intensive Care Daily Benefit Daily Prescription Drug Benefit Off the Job Accident Benefit Critical Illness Benefit	\$20 copay, 3/year \$200/day up to 3 days \$100/day \$2,000 N/A \$20 copay N/A \$5,000	\$20 copay, 3/year \$250/day up to 3 days \$200/day \$4,000 \$250/day \$20 copay N/A \$5,000
Telemedicine—Teladoc	Included	Included

To locate a provider, visit www.firstthealth.com and select Locate a Provider. Click on “Locate a First Health Network Provider Now”.

MEDICAL RATES PER PAY PERIOD—WEEKLY		
COVERAGE LEVEL	Premium MEC	Super MEC
Employee Only	\$24.02	\$27.53
Employee + Spouse	\$43.89	\$50.92
Employee + Child(ren)	\$34.89	\$41.50
Employee + Family	\$53.38	\$63.51

MEMBER RESOURCES - *Lucent Health*

LUCENT HEALTH MEMBER WEBSITE

Your unique online health plan resource.

AVAILABLE RESOURCES

Login or create an account to view and maintain your health plan information. You are able to:

- View your health plan benefits and summaries
- Print temporary ID cards
- Find a network healthcare provider
- View your healthcare claims and deductible/out of pocket balances

In order to complete registration you will need information from your health coverage ID card.

Login

Username

Password

Submit

[Forgot your username or password?](#)

Register Account

Contact Us



MEDICAL COVERAGE - United Healthcare

Deductible runs from January 1, 2026 - December 31, 2026

FIND A NETWORK PROVIDER

- Call (866) 633-2446
- Visit www.myuhc.com

BENEFIT	EI36 (POS)
Network	NexusACO OAP
Lifetime Maximum	Unlimited
General Level of Coverage	80/20
Calendar Year Deductible Individual / Family	\$5,000 / \$10,000
Maximum Out-of-Pocket Individual / Family	\$7,900 / \$15,800
Preventative Care	Covered 100%
Physician Services Primary Care Specialist Care Virtual Visits	¹ Designated Network - \$15; Network - \$45 \$0 for depts under 19 ¹ Designated Network - \$50; Network - \$125 \$0
Hospital/Emergency Services Inpatient Emergency Room Urgent Care	\$500 + Deductible + 20% \$300 + Deductible + 20% \$50
Outpatient Services Diagnostic Lab & X-Ray Outpatient Surgery Complex Imaging	Deductible + 20% ¹ Designated Network - Deductible + 20%; Network - \$250 + Deductible + 40% Deductible + 20%
Prescription Drugs Tier I Tier II Tier III Mail Order (90-day supply)	\$10 \$35 \$60 2.5X Copay
OUT-OF-NETWORK BENEFITS	
Deductible (Individual/ Family)	\$5,000 / \$10,000
Out of Pocket Maximum (Individual/Family)	\$10,000 / \$20,000
Coinsurance	50/50

¹When members utilize the services from Specialists participating in the Designated Network, the lesser copayment on their plan is applied. For more information, see page 10.

MEDICAL RATES PER PAY PERIOD—WEEKLY	
Employee Only	\$209.31
Employee + Spouse	\$460.50
Employee + Child(ren)	\$387.23
Employee + Family	\$669.81

PROVIDER FINDER - *United Healthcare*

With a PCP, there's a doctor in your corner

Your primary care provider (PCP) is your health guide—someone who can help connect you to the care you need and help you avoid cost surprises. A PCP can be a family practitioner, internist, pediatrician or general medicine physician.* Although your plan may not require you and each covered family member to select a network PCP,** it can be a good idea to have one.

Your PCP:



Generally knows your health history and health goals



Provides routine care, which may help identify potential health issues earlier



Advises you when to see a specialist and provides electronic referrals

*Lives in some states allow you to choose a specialist, like an OB/GYN, as your PCP.
**Depending on your health plan, selection of a PCP may be required.



Keep up on preventive care

Preventive care—such as routine wellness exams and certain recommended screenings and immunizations—is covered by most of our plans at no additional cost when you see network providers. A preventive care visit may be a good time to help establish your relationship and create a connection for future medical services. Learn more at uhc.com/health-and-wellness/preventive-care.



Choose a doctor

The **UnitedHealth Premium®** program uses national, evidence-based, standardized measures to evaluate physicians in various specialties to help you locate quality providers. Find UnitedHealth Premium Care Physicians by going to myuhc.com > **Find Care & Costs** and look for blue hearts.



Find a network provider

Sign in to myuhc.com > **Find Care & Costs** to find a network PCP, clinic, hospital or lab based on location, specialty, availability, hours of operation and more. You can even see patient ratings and view average costs before you choose a provider. If you would like more information about a provider's qualifications, call the member phone number on your ID card.



DESIGNATED NETWORK PROGRAM

The Designated Network Program uses national industry standards to evaluate for quality and local market benchmarks for cost efficiency across 21 specialties, including family practice, internal medicine, pediatrics, cardiology, and orthopedics.

Physicians who meet the quality and cost efficiency standard may have lower surgery repeat rates, follow evidence-based guidelines for care, and may be more likely to be aware of the latest research and clinical trials. Quality guidelines are based on standards from organizations such as: American College of Cardiology, Ambulatory Care Quality Alliance, and Agency for Healthcare Research and Quality (a division of the US Department of Health & Human Services).

Choose smart. Look for blue hearts.

Choosing a physician is one of the most important health decisions you'll make. The UnitedHealth Premium® program can help you find physicians who are right for you and your family.

Connecting you to quality care

UnitedHealth Premium program evaluates physicians in various specialties to identify those who meet the quality care criteria, which includes safe, timely, effective and efficient care. It's easy to find a UnitedHealth Premium Care Physician. Go to myuhc.com® or the UnitedHealthcare® app, click **Find a Provider** and look for the blue hearts next to the provider's name.

Here to help make your health a priority

Studies show that people who actively engage in their health care decisions have fewer hospitalizations, fewer emergency visits, higher utilization of preventive care and overall lower medical costs.

As your health ally, we're committed to helping you make informed decisions when seeking out and choosing a provider.

Look for the following icon and description



Premium Care Physician

When you see the blue hearts, you can be sure that the physician meets the criteria for safe, timely, effective and efficient care.



Thomas, John A, MD

Knee Surgery, Orthopedic Surgery

1307 8th Ave Ste 603
Fort Worth, TX 76104

0.9 Miles Away | [Get Directions](#)

(817) 926-2663 Phone
711 TTY

[Additional Locations \(3\)](#)

♥♥ Premium Care Physician

✓ Accepting All Patients

✓ In-Network Provider

★★★★★ (16)

You May Owe

*N/A

[Login To View Costs >](#)

[View Services & Costs](#)

MEMBER RESOURCES - *Mobile App*

It's easier to connect to your plan

Your benefits include personalized digital tools that help you check in on your plan whenever you want—which helps make it easier to stay on top of your benefit details.



Activate your myuhc.com account

When it comes to managing your health plan, **myuhc.com**® lets you see what's covered, manage costs and so much more. To help everyone get more from their plan, it's important that each member age 18 and over consider creating their own account.

Use **myuhc.com** to:

- Find the average cost of care
- See what's covered
- View claim details
- Check your plan balances
- Find network providers

Get started today:

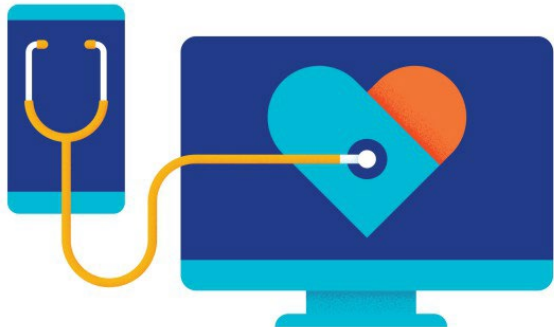
- Go to **myuhc.com > Register Now**
- Have your ID card handy and follow the step-by-step instructions



Download the UnitedHealthcare app

The UnitedHealthcare® app puts your health plan at your fingertips. Download it to:

- Find nearby care options in your network
- View and share your health plan ID card with your doctor's office
- Video chat with a doctor 24/7



24/7 Virtual Visits

Get care, virtually anywhere

With 24/7 Virtual Visits, you can connect to a doctor by phone or video* through **myuhc.com**® or the United Healthcare® app. 24/7 Virtual Visits doctors are part of a select group of providers focused on providing quality virtual care when you need it. They can treat a wide range of health conditions, from flu and pinkeye to migraines and more, and can even prescribe medication* as needed. 24/7 Virtual Visits can treat many of the same conditions as an ER or urgent care, so it may be a good option to use as an alternative - particularly in times when your primary care provider isn't available. 24/7 Virtual Visits can save you \$130 compared to an urgent care visit and up to \$2,000 compared to an ER visit.



LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Special Enrollment Rights

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later 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 enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification with 60 days after you or your dependent is terminated from, or determined to be eligible for such assistance.

Marriage, Birth or Adoption

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

For More Information or Assistance

To request special enrollment or obtain more information, contact:

Aviation Personnel
Michael Holloway/Director of Finance & Administration
4756 Hwy 377 South
Fort Worth, Texas 76116
(817) 244-2125

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 Aviation Personnel and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription 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. Aviation Personnel has determined that the prescription drug coverage offered by the Aviation Personnel medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare prescription drug plan, as long as you later enroll within specific time periods.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription drug plan, you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7 but as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the

Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting Aviation Personnel at the phone number or address listed at the end of this section.

If you choose to enroll in a Medicare prescription drug plan and cancel your current Aviation Personnel prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

For more information about this notice or your current prescription drug coverage:

Contact the Human Resources Department at:
817-244-2125

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You may also request a copy.

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 will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription 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 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 800-772-1213. TTY users should call 800-325-0778.

Remember: Keep this Creditable Coverage notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, 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 whether or not you are required to pay a higher premium (a penalty).

January 1, 2026
Aviation Personnel
Michael Holloway/Director of Finance & Administration
4756 Hwy 377 South
Fort Worth, Texas 76116
(817) 244-2125

Notice of HIPAA Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information known as protected health information (PHI), includes virtually all individually identifiable health information held by a health plan - whether received in writing, in an electronic medium or as oral communication. This notice describes the privacy practices of the Employee Benefits Plan (referred to in this notice as the Plan), sponsored by Aviation Personnel, hereinafter referred to as the plan sponsor.

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. It is important to note that these rules apply to the Plan, not the plan sponsor as an employer.

You have the right to inspect and copy protected health information which is maintained by and for the Plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask the Human Resources Department to amend the information. For a full copy of the Notice of Privacy Practices describing how protected health information about you may be used and disclosed and how you can get access to the information, contact the Human Resources Department.

Complaints: If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint, please contact the Privacy Officer.

Aviation Personnel
Michael Holloway/Director of Finance & Administration
4756 Hwy 377 South
Fort Worth, Texas 76116
(817) 244-2125

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance

Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

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 are 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 are not 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, 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 go to www.insurekidsnow.gov to find out how to apply. If you qualify, you can 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 are not 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 March 17, 2025. Contact your State for more information on eligibility.

FLORIDA – MEDICAID

Website: <https://www.flmedicaidprecovery.com/flmedicaidprecovery.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

KANSAS – MEDICAID

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

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)

NORTH CAROLINA – MEDICAID

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

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

NEVADA – MEDICAID

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

OKLAHOMA – MEDICAID AND CHIP

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

SOUTH CAROLINA – MEDICAID

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

TEXAS – MEDICAID

Website: <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>
Phone: 1-800-440-0493

To see if any other States have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, you can 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

Continuation of Coverage Rights Under COBRA

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if you are covered under Aviation Personnel group health plan you and your eligible dependents may be entitled to continue your group health benefits coverage under Aviation Personnel plan after you have left employment with the company. If you wish to elect COBRA coverage, contact your Human Resources Department for the applicable deadlines to elect coverage and pay the initial premium.

Plan contact information

Aviation Personnel
Michael Holloway/Director of Finance & Administration
4756 Hwy 377 South
Fort Worth, Texas 76116
(817) 244-2125

Your Rights and Protections against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

- Emergency services – If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.
- Certain services at an in-network hospital or ambulatory surgical center – When you get

services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact your insurance provider. Visit www.cms.gov/nosurprises for more information about your rights under federal law.



AVIATION PERSONNEL

This brochure highlights the main features of the employee benefits program. It does not include all plan rules, details, limitations, and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are final authority. The rights are reserved to change or discontinue the employee benefits plans at any time.



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