BENEFITS OPEN ENROLLMENT

Variable Hour Employees

WHITEWATER EXPRESS CAR WASH

2025-26

Insurance / Risk Advisory / Employee Benefits
HORTON

WhiteWater Express Car Wash
Variable-Hour Benefits Guide

Our Promise

We are committed to providing our greatest assets – our people – with comprehensive and affordable benefits. Our 2025-26 Employee Benefits offerings deliver maximum options and flexibility. This guide will help you understand the full range of health and wellness benefits that will be available. After reading through the enclosed information, be sure to use this guide as a benefits resource you can reference throughout the year.

This guide includes a quick reference directory of telephone numbers and websites for all of our providers. We encourage you to access these sites to learn more about the plans and make the best choices possible.

Protect your Health, Life & Well-Being

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Eligibility & Enrollment

Who is Eligible?

Variable-hour employees working less than an average of 30 hours per week and their eligible family members can enroll in the benefits described in this guide. Eligible family members include legal spouses, domestic partners, and dependent children up to age 26.

When are you Eligible?

Variable-hour Employees:

Benefits are effective the 1st day of the month following 30 days of employment.

Annual Open Enrollment:

You may make changes to your benefit elections in ADP during your open enrollment period in January for an effective date of February 1st.

Qualified Change in Status:

You may make benefit changes within 30 days of a qualified event. Qualified events include marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death, and change in residence due to an employment transfer for you or your spouse or changed in spouse's benefits, or employment status.

Note: Employee is responsible for notifying Human Resources of any changes within 30 days.

Enrollment Instructions

1. Review the information in this guide and benefit plan summaries.
2. You must complete your enrollments in the ADP Workforce Now online portal at www.login.adp.com/welcome.
3. You will not be allowed to make changes after the open enrollment window closes, unless you experience a qualifying life event.

Medical Insurance

river

Medical Coverage	Complete Plan	Essential Plan
	In-Network Only	In-Network Only
	River Health	River Health
Policy Year Deductible		
Individual	$0	$0
Family	$0	$0
Policy Year Out-of-Pocket Maximum		
Individual	None	None
Family	None	None
Coinsurance (You Pay)	Not Applicable	Not Applicable
Policy Year Annual Benefit Maximum	**$10,000**	**None**
Physician Services		
Primary Care Physician (PCP)*	No Charge	No Charge
Specialist Care Physician (SPC)**	No Charge	No Charge***
Virtual Visits	No Charge	No Charge
Preventive Care	No Charge	No Charge
Urgent Care	Covered up to Annual Maximum	No Charge
Hospital Services		
Inpatient Stay	Covered up to Annual Maximum	Not Covered
Outpatient Surgery	Covered up to Annual Maximum	Not Covered
Emergency Room	Covered up to Annual Maximum	Not Covered
Prescription Drugs		
Retail (up to a 30-day supply)	No Charge	No Charge
Mail Order (up to a 90-day supply)	No Charge	No Charge
Semi-Monthly Costs		
Employee Only	$47.50	$7.50
Employee & Spouse	$75.00	$22.50
Employee & Child(ren)	$100.00	$57.50
Employee & Family	$160.00	$107.50

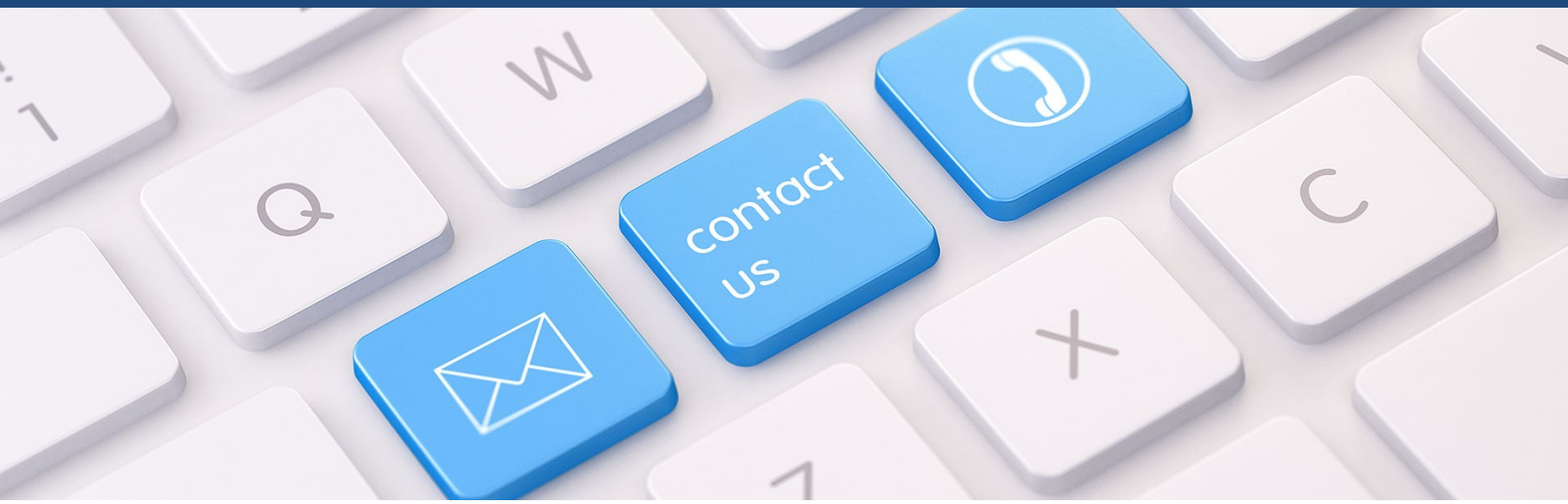
*Limited to 3 visits per policy year. **Limited to 5 visits per policy year.

***Only covered specialists are OBGYNs & Dermatologists.

See Certificate of Coverage for full policy details including limits and exclusions – for a copy see Human Resources.

To identify an in-network provider go to www.river.health

Contact Information

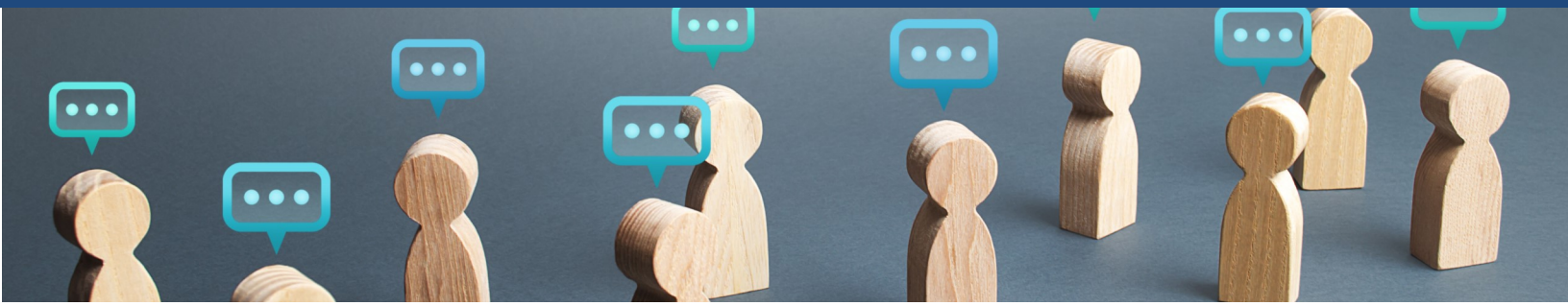


Benefit	Carrier	Phone	Website
Medical	River Health	888-814-6062	river.health
Telemedicine	River Health	N/A	https://www.river.health/virtual-care
Prescriptions	River Health	N/A	https://www.river.health/prescriptions
Labs	River Health	N/A	https://www.river.health/labs
Office Visits	River Health	N/A	https://www.river.health/office-visits
Therapy	River Health	N/A	https://www.river.health/therapy

Human Resources	
Carmen Trujillo HR Manager (346) 367-2507 carmen@whitewatercw.com	Ron Holmes HR Benefits Specialist (281) 803-8878 rholmes@whitewatercw.com

The Horton Group	
Mackenzie Fisher Account Manager 708-845-3039 mackenzie.fisher@thehortongroup.com	Fatin Elayyan Senior Client Service Representative 708-315-7141 fatin.elayyan@thehortongroup.com

Employee Benefits Terminology



Health Care Benefits: Health Care Benefits provide preventive and protective coverage for medical, dental, vision, and prescription drugs for employees and their qualified dependents.

Medical care plans provide services or payments for services rendered in the hospital or by a qualified medical care provider.

BALANCE BILLING: When out-of-network providers bill for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider cannot balance bill you for the covered services.

BENEFICIARY: A designated person who is the recipient of proceeds from an insurance policy.

BIOMETRIC SCREENING: Usually a series of Body Mass Index (BMI) measurements and blood tests (e.g. pressure, cholesterol, and glucose) used to gauge an individual's overall health.

COINSURANCE: The percentage the plan or you pay for a covered service or supply. For example, the plan may pay 80 percent while you pay 20 percent.

COPAYMENT (COPAY): A copay is a flat-dollar amount you pay for specific covered services upon each visit to the provider. It is not impacted by the plan deductible, coinsurance, or out-of-pocket maximum.

DEDUCTIBLE: The amount you pay each year before the plan begins to pay coinsurance.

DEPENDENT: Relative of an employee who may be eligible for benefits' coverage if they meet certain criteria. Many benefits plans offer coverage to spouses, domestic/civil union partners, and children up to age 26 who are totally or substantially reliant on their parents for support, thereby defined as "dependent children."

ELIGIBLE EXPENSE: This is the amount on which payment is based for covered medical services; may also be called "allowed amount maximum," "payment allowance" or "negotiated rate." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

ELIMINATION PERIOD: The period of time before you're eligible to receive benefits. Also known as the "waiting period."

EMPLOYEE CONTRIBUTION: The amount an employee contributes through payroll deductions for their medical and other insurance and savings program benefits.

EVIDENCE OF INSURABILITY (EOI): The documentation of the good health condition of the insurance beneficiary and his/her dependent's health in order to be approved for coverage. It is only required in certain circumstances.

EXPLANATION OF BENEFITS (EOB): After you receive medical services, your insurance will provide you with an EOB. It will outline details regarding how your insurance processed your medical claim, including what portion of the charges your insurance paid and what portion, if any, you are responsible for paying.

FLEXIBLE SPENDING ACCOUNT (FSA): An FSA is a tax-advantaged account that lets you put money aside on a pre-tax basis to pay for a wide range of health and/or dependent care expenses (as defined by the IRS) not covered by your plan that you incur during the plan year.

Unlike the HSA, any unused funds remaining after the plan year ends will be forfeited.

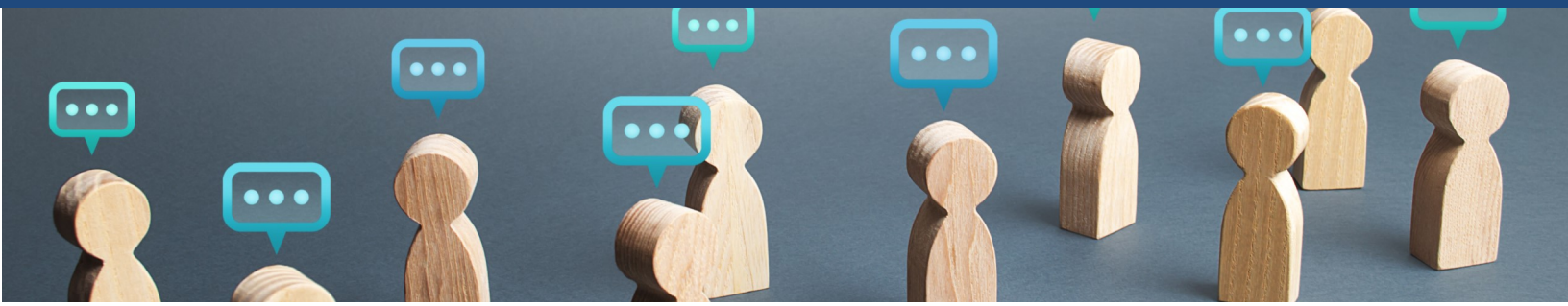
FORMULARY: A medical plan's formulary is a preferred brand-name drug list of the most cost-effective outcome-based drugs. You pay less when using a drug on the plan's formulary list.

HEALTH SAVINGS ACCOUNT (HSA): An HSA is a tax-advantaged savings account for high-deductible health plan (HDHP) participants that lets you put money aside on a pre-tax basis to pay for a wide range of health care expenses (as defined by the IRS) not covered by your plan. Unused money remaining in the account at the end of the plan year rolls over to be used the next year. Please refer to IRS Publications 502 and 969 for complete details on eligible expenses.

HSA CONTRIBUTION: This refers to a contribution, or "deposit," an employee may make to his/her HSA or a deposit made by the company to the HSA of an employee participating in the HDHP.

HIGH-DEDUCTIBLE HEALTH PLAN: A plan that provides competitive health insurance along with a tax-advantaged health savings account (HSA) that lets you decide how to spend your health care dollars. Essentially, you pay a lower premium in exchange for a higher deductible, much like car insurance.

Employee Benefits Terminology



HIPAA: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT: HIPAA is a legal requirement that regulates how organizations must handle Protected Health Information (PHI).

IN- AND OUT-OF-NETWORK PROVIDERS: The facilities, providers, and suppliers a health insurance carrier contracts with to provide medical services at a pre-negotiated discount. You generally pay less out of pocket when you use in-network providers. Benefit plans develop networks by contracting with doctors, hospitals, labs, etc., who have agreed to provide health care services to members at negotiated rates. You generally pay less out-of-pocket when you use in-network providers.

INSURED: Person(s) covered under the medical plan to receive treatment and services. Includes primary insured (usually the employee) and their designated dependents.

INSURER: The company that underwrites and assumes the insurance risk for your medical plan. Also known as "insurance carrier."

MAXIMUM DOLLAR LIMIT: The maximum amount payable by the insurer for covered expenses for the insured and each covered dependent while the ensured is enrolled in the health plan. Plans can have a yearly or lifetime maximum dollar limit. The most typical maximum limit is a lifetime amount of $1 million per individual.

MEDICALLY NECESSARY: Medical services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine and are covered under your medical plan.

OUT-OF-POCKET MAXIMUM: The maximum amount you will pay out of pocket for covered medical expenses per calendar year, including your deductible. After your share of covered expenses reaches this annual limit, the plan pays 100% for eligible network services and supplies for the remainder of the calendar year.

POLICY HOLDER: A person or group in whose name an insurance policy is held.

PREFERRED PROVIDER ORGANIZATION (PPO) PLAN: A type of health plan that contracts with doctors, hospitals, labs, and other health care providers to create a network of participating providers. You generally pay less when you use providers that belong to the PPO network. You may use providers that fall outside of the plan's network at an additional cost. This type of plan typically has higher premiums and a lower deductible than a high-deductible health plan (HDHP).

PREMIUM: The contracted amount that must be paid for a health insurance plan by covered employees, by their employer, or is shared by both. A covered employee's share of the annual premium is generally paid periodically, such as bi-weekly or monthly, and deducted from his or her paycheck.

PREAUTHORIZATION: A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called prior authorization, prior approval or precertification, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM: The maximum amount you will pay out of pocket for covered prescription drug expenses per calendar year. After your share of covered prescription drug expenses reaches this annual limit, the plan pays 100 percent for eligible prescription drugs for the remainder of the calendar year. The prescription drug out-of-pocket maximum is separate from the medical out-of-pocket maximum.

PRESCRIPTION DRUG PLANS: Provide coverage for outpatient prescription drugs. Prescription drugs dispensed during a hospital stay are covered as hospital miscellaneous charges.

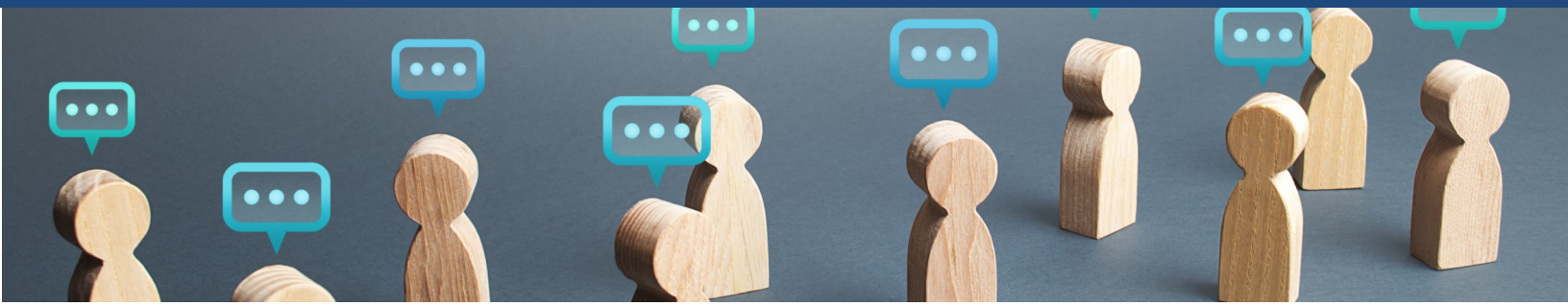
Name-brand drugs — These are drugs that once were or still are, under patents.

Generic drugs — These are drugs that are not under patent. Once a drug's patent has expired, some plans provide more generous coverage for same-formula generic drugs than for name-brand drugs. The practice is adopted as a cost-containment measure.

Mail-order drugs — These are drugs that can be ordered through the mail. As a cost-containment measure, some plans use mail-order

PRE-TAX DEDUCTION: Payments deducted from your gross pay before Medicare, Federal, and State taxes are calculated, thus reducing your taxable wages and tax liability.

Employee Benefits Terminology



PRIMARY CARE PHYSICIAN (PCP): A physician who directly provides or coordinates a wide range of medical services for a patient. Primary Care Physicians include Medical Doctors, Doctors of Osteopathic Medicine, Internists, Family Practitioners, General Practitioners, OB/ GYNs, and Pediatricians. The opposite of a specialist.

PROVIDER: A physician, healthcare professional or healthcare facility, certified or accredited as required by state law and mentally fit.

QUALIFYING LIFE EVENT (QLE): A change in your life that allows you to make changes to your benefits' coverage outside of the annual open enrollment period. These changes include a change in marital status (marriage, divorce, death of spouse), a change in the number of eligible children (birth, adoption, death, aging-out), and a change in a family member's benefits eligibility under another plan (losing a job, Medicare or Medicaid eligibility, etc.).

REASONABLE AND CUSTOMARY (R&C) CHARGES: The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount sometimes is used to determine the allowed amount.

SPECIALIST: A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat6 certain types of symptoms and conditions. The opposite of a Primary Care Physician (PCP). For example, a Dermatologist is considered a specialist.

SUMMARY PLAN DESCRIPTION (SPD): An important document that tells plan participants what the plan provides and how it works.

WELLNESS: Wellness refers to a healthy state of being. Many employers have wellness programs that encourage and sometimes incentivize employees to become more physically and mentally fit.

Notes

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