PF HOLDINGS

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Thrive in 2025 Benefits Guide

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Information on your 2025 benefits is available on Workday > Announcements > Benefits Information > Benefits Enrollment Portal.

Scan the QR code to get started!

See page 28 for important information concerning Medicare Part D coverage.

In this Guide, we use the term Company to refer to PF Holdings. This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the Company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Annual Enrollment

Each year, PF Holdings evaluates our plans and what options are available in the market to provide you and your family comprehensive, competitive, and best-in-class options. We encourage you to consider how you can make the most of PF Holdings benefits to get the care you need and reduce your out-of-pocket costs. Take a look at your healthcare usage from previous years — understanding you and your family's specific needs is the first step to becoming a wise healthcare consumer.

Choose your benefits

You can elect or change your benefits for the 2025 plan year during Annual Enrollment, **November 6–20, 2024** for benefits that are effective January 1, 2025. Due to IRS regulations, once you have made your choices for the plan year, you won't be able to change your benefits until the next plan year unless you experience a qualifying life event.

Making changes to your benefits after Annual Enrollment

- You can make changes to some of your benefits in 2025 if you experience a Qualifying Life Event (QLE), such as getting married or having a baby. You must make the change within 31 days of the event. See page 5 for more information.
- If you need to enroll in benefits or change your benefit elections for 2024 due to a QLE or status change, please follow the current benefits enrollment process outlined on page 6.
- You can enroll year-round in Pet Insurance and Auto and Home Insurance.

What if I don't take action during Annual Enrollment?

- Your current coverage will continue — both the plans and the dependents you currently cover — for medical, dental, vision, life and accident insurances, and voluntary benefits.
- You will have Short Term Disability through the company, but will default to no Long Term Disability coverage unless you make an LTD election for 2025.
- Health Savings Account (HSA) and Healthcare and Dependent Care Flexible Spending Account (FSA) elections do not roll over from year to year. You must make a new election each year to participate. If you have unused funds in your FSA at the end of 2024, you must elect an FSA for 2025 to carry them over to the next year; if not, the unused funds will be forfeited.

Have Medicare?

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 the creditable prescription drug coverage and Medicare notice in the legal notices at the back of this booklet for more details.

What's New in 2025?

Discover what's new before enrolling in your 2025 benefits. More details about these plans can be found in this guide and on Workday (Announcements > Benefits Information > Benefits Enrollment Portal).

Disability Benefit Changes

In 2025, our Short Term Disability (STD) benefit will be provided **at no cost to you!** This benefit will cover up to **60% of your salary (up to $1,250 per week) for up to 13 weeks** if you are approved for disability due to an accident, illness, or birth of a child. No action is needed from you to enroll in this benefit as all employees will be provided this benefit effective January 1, 2025 and ongoing.

You have the option to purchase Long Term Disability (LTD) coverage to continue a portion of your salary if your illness or disability continues after 13 weeks. You must elect LTD during Annual Enrollment or later in the year if you have a qualifying life event. Please note late enrollment may require evidence of insurability (EOI).

NEW Adoption Assistance Benefit

Beginning in 2025 PF Holdings will help cover expenses such as court fees, agency fees, and foreign adoption fees, up to a lifetime maximum of $10,000.

Mercer Marketplace 365+ is Now Aptia365

This year, you'll see a new name when you enroll. Mercer Marketplace 365+ is now Aptia365. Despite the name change, you'll still have access to the same enrollment resources and tools.

Eligibility & Enrollment

You and your family have unique needs, which is why PF Holdings offers a variety of benefit plans from which to choose. If applicable, be sure to consider your spouse's benefits through their place of employment and your dependents' eligibility when weighing each option.

Eligibility

If you are a full-time employee of PF Holdings who is regularly scheduled to work at least 30 hours per week, you are eligible to participate in the medical, dental, vision, life and disability plans, along with additional supplemental insurance plans.

When Does Coverage Begin for a New Hire?

The elections you make during your enrollment are effective on your eligibility date, which is the first of the month following 30 days of service.

Enrollment elections are effective January 1, or based on your hire date if you are a new hire:

Hire Date	Benefits Effective Date
Nov. 2 – Dec. 2, 2024	Jan. 1, 2025
Dec. 3, 2024 – Jan. 2, 2025	Feb. 1, 2025
Jan. 3 – 30, 2025	March 1, 2025
Jan. 31 – March 2, 2025	April 1, 2025
March 3 – April 1, 2025	May 1, 2025
April 2 – May 2, 2025	June 1, 2025
May 3 – June 1, 2025	July 1, 2025
June 2 – July 2, 2025	Aug. 1, 2025
July 3 – Aug. 2, 2025	Sept. 1, 2025
Aug. 3 – Sept. 1, 2025	Oct. 1, 2025
Sept. 2– Oct. 2, 2025	Nov. 1, 2025
Oct. 3 – Nov. 1, 2025	Dec. 1, 2025
Nov. 2 – Dec. 2, 2025	Jan. 1, 2026
Dec. 3, 2025 – Jan. 2, 2026	Feb. 1, 2026

Eligible Dependents

Dependents eligible for coverage in the PF Holdings benefits plans include:

- Your legal spouse (including common law spouses)
- Children up to age 26 (includes birth children, stepchildren, legally-adopted children, children placed for adoption, foster children, and children for whom legal guardianship has been awarded to you or your spouse)
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by the medical carrier to continue coverage past age 26

Verify Your Dependents to Include Them in Your Coverages

- If you want to cover dependents on your medical, dental, and vision plans, **you are required to complete dependent verification by submitting the required documents (e.g., birth certificate, marriage license) to demonstrate the relationship between yourself and your dependents**. After you enroll, you will be provided more information about this process and what documents are required.
- If the dependent is rejected or the proper documents are not received by the deadline outlined in your dependent verification notice, the dependent will be removed and will not have coverage under your plan.
- You will not have the option to make changes to your coverage again until the next Annual Enrollment or unless you have a qualifying life event throughout the year. Be on the lookout for more information after Annual Enrollment.

Qualifying Life Events (QLE)

When one of the following events occurs, you have 31 days from the date of the event to notify the Benefits Department and/or request changes to your coverage.

- Change in your legal marital status (marriage, divorce, or legal separation)
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Change in your spouse's employment status (resulting in a loss or gain of coverage)
- Change in your employment status from full-time to part-time, or part-time to full-time, resulting in a gain or loss of eligibility. NOTE: If you drop below 30 hours per week you may be able to extend your coverage due to Affordable Care Act requirements
- Entitlement to Medicare or Medicaid
- Eligibility for coverage through the Marketplace (during a Marketplace special or annual enrollment period)
- Change in your address or location that may affect the coverage for which you are eligible

Your change in coverage must be consistent with your change in status. Please direct questions regarding specific life events and your ability to request changes to the Benefits Department at benefits@profrac.com.

Preparing to Enroll

PF Holdings provides its employees the best coverage possible. Keep in mind that you may select any combination of medical, dental, and/or vision plan coverage categories. For example, you could select medical coverage for you and your entire family, but select dental and vision coverage only for yourself. The only requirement is that you, as an eligible employee of PF Holdings, must elect coverage for yourself in order to elect any dependent coverage. Be sure to have the Social Security Numbers and birth dates for any eligible dependent(s) that you plan to enroll.

How to Enroll

Go to Workday > Announcements > Benefits Information > Benefits Enrollment Portal to start your enrollment.

The first time you visit the Aptia365 website, select "Get Started" and follow the instructions provided to register.

Cost of Coverage

As a committed partner in your health, PF Holdings absorbs a significant amount of the costs. Your share of the contributions for medical, dental, and vision benefits are deducted on a pre-tax basis, which lessens your tax liability.

Please note that employee contributions for medical, dental, and vision coverage vary depending on the level of coverage you select. In general, the more coverage you have, the higher your contribution will be.

Throughout this guide, you will see bi-weekly rates for various benefits. On the months where there are three paychecks, benefit deductions will only be taken from the first two paychecks that month.

Need Help?

If you don't have access to a computer or need assistance, you can enroll with a Benefits Counselor by calling **855-200-8195**, Monday – Friday, 7 am – 9 pm CT.

Medical Benefits

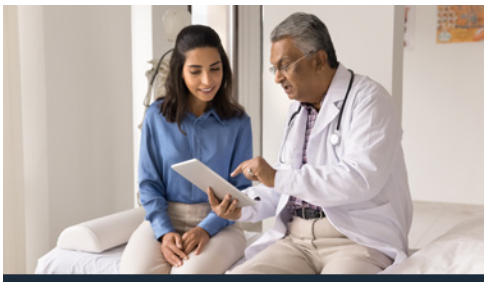
As you use your medical plan, your choices matter. PF Holdings is here to help you get the right healthcare and make a healthy difference in your life.

Your Plan Options

PF Holdings offers two plan options to fit your needs: a PPO Plan and a High Deductible Plan, both administered by BlueCross BlueShield of Texas (BCBSTX). Each plan is designed to allow you to select the option that best fits your needs.

The chart below gives a summary of the 2025 medical coverage, including what you'll pay out of your paycheck.

	PPO Plan		High Deductible Plan	
Bi-Weekly Contributions				
Employee Only	$80.91		$41.78	
Employee + Spouse	$274.83		$185.02	
Employee + Child(ren)	$213.19		$133.70	
Employee + Family	$349.66		$250.67	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible				
	Calendar Year (January 1 - December 31)		**Calendar Year (January 1 - December 31)**	
Individual	$1,500	$4,500	$2,500	$10,500
Family	$3,000	$9,000	$5,000**	$21,000
Coinsurance (Plan Pays)	80%*	60%*	80%*	60%*
Annual Out-of-Pocket Maximum (Maximum Includes Deductible)				
Individual	$6,450	$19,350	$6,450	$12,900
Family	$12,900	$38,700	$12,900	$25,800
Copays/Coinsurance				
Preventive Care	100%; no deductible	60%*	100%; no deductible	60%*
Primary Care Provider Office Visit	$30 copay	60%*	80%*	60%*
Specialist Office Visit	$50 copay	60%*	80%*	60%*
Virtual Visit (Telemedicine)	$0	N/A	$40 copay*	N/A
Airrosti Visit	$25 copay	60%*	$25 copay*	60%*
Urgent Care	$75 copay	60%*	80%*	60%*
Emergency Room	80%*	80%*	80%*	80%*
Inpatient Hospital Stay	80%*	60%*	80%*	60%*
Outpatient Hospital Stay	80%*	60%*	80%*	60%*



Urgent Care vs. Emergency Room?

Freestanding emergency rooms may look a lot like urgent care centers, but the costs and services can be drastically different. In general, consider an urgent care center as an extension of your primary care physician, while freestanding emergency rooms should be used for health conditions that require a high level of care — like you would receive in a hospital. Choosing the right care could save you hundreds of dollars.

*After Deductible

** In family coverage, your individual deductible will be embedded at $3,300 per IRS requirements.

The Plans have an embedded deductible, which means the individual deductible amount must be met by each member enrolled under your medical coverage before coinsurance applies; however, if you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will also be applied toward the "per family" deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the "per family" deductible amount.

Note: All covered services are subject to medical necessity as determined by the plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

Preventive Care

Don't just think about your health when you're sick. Annual check-ups can identify health issues early – when they may be easier and less costly to treat. Your medical plan covers in-network preventive care and screenings at 100% with no deductible required to be met. This means you can get preventive care for you and your covered family members without sacrificing your wallet.

What is Preventive Care?

Preventive care includes routine physical exams and health screenings, which are usually performed by your in-network PCP. The table below lists common preventive services based on age and gender.

Children	Female	Male
▪ Well-baby care ▪ Annual physicals ▪ Immunizations	▪ Pap tests ▪ Mammograms ▪ Osteoporosis test ▪ Annual physicals ▪ Immunizations ▪ Blood pressure checks ▪ Cholesterol checks ▪ Colonoscopy	▪ Prostate cancer screening ▪ Osteoporosis test ▪ Annual physicals ▪ Immunizations ▪ Blood pressure checks ▪ Cholesterol checks ▪ Colonoscopy

How to Find a Doctor

Visit **www.bcbstx.com** or call **800-445-2227** to find an in-network doctor near you!

Medical Plan Resources

24/7 NURSELINE

BlueCross BlueShield of Texas provides a 24/7 Nurseline for members to call; they can be reached at 800-581-0393. The Nurseline is available 24/7 for any medical questions or concerns you may have, such as what type of care you should seek or finding a provider.

VIRTUAL MEDICINE

A virtual visit with MDLIVE through BlueCross BlueShield of Texas lets you see and talk to a doctor from your phone, tablet, or computer without an appointment. Most visits take about 10 to 15 minutes, and doctors can write a prescription (in participating states). Try a virtual visit when your doctor is not available or when you're traveling. Doctors can diagnose and treat a wide range of non-emergency medical conditions, including:

- Allergies
- Asthma
- Bladder infection/
- Urinary tract infection
- Bronchitis
- Cold/Flu
- Ear problems (age 12+)
- Fever (age 3+)
- Nausea
- Pink eye
- Rash
- Sinus problems
- Sore throat
- Stomach ache

The cost for a visit is $0 if you are enrolled in the PPO Plan or $40 if you are enrolled in the High Deductible Plan.

Visit **mdlive.com/bcbstx** to request a virtual visit today!

Try virtual therapy today!

Talk Therapy, offered by MDLIVE, allows members to speak with a licensed counselor, therapist, or psychiatrist for support. You can choose who you want to work with for issues including:

- Addiction
- Stress and anxiety
- Bipolar disorders
- Depression
- Eating disorders
- Grief and loss
- Panic disorders
- Trauma and PTSD
- Relationship issues

The cost for a behavioral health visit is $0 if you are enrolled in the PPO Plan. If you are enrolled in the High Deductible Plan, the cost will vary by the type of provider you select (counselor vs psychiatrist).

AIRROSTI MUSKOSKELETAL BENEFIT

PF Holdings offers an Airrosti benefit at a lower office visit copay under the PPO Plan. A remote Airrosti benefit is also available. The visit will be subject to deductible and coinsurance under the High Deductible Plan.

Airrosti providers are experts at quickly diagnosing and resolving the source of musculoskeletal injuries. You can get an assessment, diagnosis, treatment, and exercise therapy designed to eliminate the pain associated with many common conditions, allowing you to quickly and safely return to normal activity – usually within 3-6 visits. You are allowed up to 12 visits per calendar year. Call 800-404-6050 or visit www.airrosti.com to schedule your in-person or remote appointment.

Note: Airrosti providers are not available in all areas. Remote appointments may not be available in some areas.

BLUE ACCESS FOR MEMBERS

Get information about your health benefits, anytime, anywhere. Use your computer, phone, or tablet to access the BlueCross BlueShield of Texas secure member website, Blue Access for Members (BAM℠). With BAM, you can:

- Check the status or history of a claim
- View or print Explanation of Benefits (EOB) statements
- Locate a doctor or hospital in your plan's network
- Find Spanish-speaking providers
- Access your electronic ID card, request a new ID card, or print a temporary one

All you have to do is:

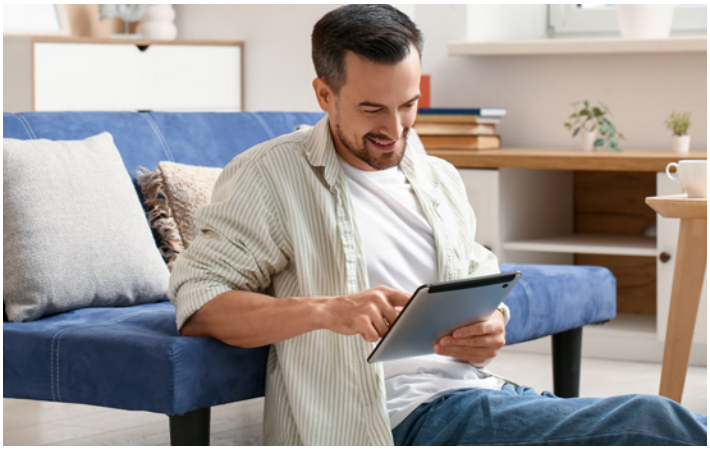
1. Go to bcbstx.com
2. Log in or sign up using your member ID card to complete your registration

APTIA365 HUB

When you enroll in a medical plan, you are eligible to elect the Aptia365 HUB benefit. With the Aptia365 HUB, you will get personalized support to help improve the quality and cost of your care, 365 days a year.

Advantages include:

- **Support for claims and billing issues, test results and treatments –** A Personal Health Advocate (PHA) will guide you and your family through medical-related questions or concerns. PHAs can assist with finding a provider or facility and provide unbiased support throughout all phases of medical care
- **Access to negotiation experts to help lower medical bills –** Anytime you have a medical bill that is over $400 and not covered by insurance, a skilled negotiation team will work with your providers to get a discount
- **Help finding doctors** who provide high-quality care for your needs so you can review the quality scores of doctors in your area, recover faster, and save money
- **The best price for your healthcare** service so you can be prepared in advance and compare costs
- **An expert second opinion for peace of mind** – World-class specialists will review your case and give you an expert opinion on your diagnosis and treatment plan



Pharmacy Benefits

Pharmacy benefits are administered by CVS Caremark. What you pay for a prescription depends on the medical plan you enroll in, as well as the prescription tier (generic, preferred brand, etc.).

Please note – if you enroll in a medical plan, you will automatically be enrolled in the prescription drug plan.

	PPO Plan	High Deductible Plan
	In-Network	In-Network
Retail Rx (30-day supply)		
Preventive	Varies by Preventive Prescription Tier**	Varies by Preventive Prescription Tier**
Generic	$10 copay	80%*
Preferred Brand	$40 copay	80%*
Non-Preferred Brand	$60 copay	80%*
Specialty	$75 copay	80%*
Mail Order (90-day supply)		
Generic	$25 copay	80%*
Preferred Brand	$100 copay	80%*
Non-Preferred Brand	$150 copay	80%*
Specialty	Not covered	80%*

*After Medical Deductible

**Under both the PPO Plan and High Deductible Plan, certain preventive medications will be covered at a 100%. Please go to www.caremark.com to review the preventive drug coverage.

Note: If you visit an out-of-network pharmacy, you will need to file a claim for reimbursement. If you use an out-of-network pharmacy under the PPO Plan, you will pay an additional 20%. Out-of-Network mail order is not covered. Specialty drugs must be obtained from CVS Caremark Specialty Pharmacy.

Go generic, when available.

Generics are FDA-approved medications that can be made once the patent of a brand-name medication expires. Generic drugs cost less and can work just as well. If you fill a brand-name prescription and a generic is available, you will pay the cost difference between the brand-name medication and the generic medication, in addition to the copay or coinsurance for the prescription. This applies when a brand-name medication is filled for any reason, regardless if it is prescribed by the doctor.

Did you know...?

Diabetic testing supplies (strips and lancets) are covered at $0 member cost under both medical plans!

Pharmacy FAQs

Where can I fill prescriptions?
You can fill prescriptions at your local CVS pharmacy along with many other national pharmacy chains.

Do I have a prescription ID card?
No, you will only have one ID card for both medical care and prescriptions.

What are prescription tiers?
Prescription tiers are a way that health insurance plans group medications based on how much they cost. Each tier represents a different level of cost you pay for the prescription with preventive and generic as lower cost and specialty as highest cost.

How do I know what tier my medication is in?
Visit www.caremark.com to review drug cost and coverage.

How can I save money on my prescriptions?
Apps and prescription discount programs such as GoodRx, Amazon Prime RX Savings, and Optum Perks let you compare prices of prescription drugs and find possible discounts.

Savings & Spending Accounts

You can save money on healthcare costs like office visits, eye exams, prescription expenses, over-the-counter medications, and more* when you use tax-advantaged accounts.

* See IRS Publication 502 for a full list of eligible expenses.

Healthcare Flexible Spending Account (FSA)

If you enroll in the PPO Plan, you can open a Healthcare FSA to pay for healthcare expenses like deductibles, copays, prescriptions, dental and vision expenses. You avoid paying income taxes on the amount you contribute to the FSA because the money comes out of your paycheck before federal, state, and Social Security taxes are calculated — and it's not taxed when you use it to pay for eligible expenses.

Health Savings Account (HSA)

An HSA is a helpful, tax-advantaged tool to save on healthcare expenses — now or in the future. The HSA is always yours, even if you leave PF Holdings. The money in your account rolls over from year to year if you don't use it.

Once your HSA reaches a certain balance, you can invest a portion of your money in mutual funds to grow your balance. When you reach age 65, you are also able to withdraw HSA funds for any purpose without penalty charges (although you will need to pay taxes).

HOW DOES THE HSA HELP ME SAVE ON TAXES?

The money in your HSA is triple-tax protected*, meaning no federal tax on:

- Money contributed
- Interest or investment earnings
- Money withdrawn to pay for eligible healthcare expenses

* In some states, you'll pay taxes on the money you put into your HSA.

Did you know...?

Regardless of what medical plan you enroll in, you have access to a Dependent Care Flexible Spending Account (FSA). The Dependent Care FSA allows you to set aside pre-tax funds to help pay for expenses associated with caring for elder or child dependents. See the "Additional Benefits" section for more information.

You are eligible to open and fund an HSA if:

- You are enrolled in an HSA-eligible High Deductible Plan
- You are not covered by your spouse's non-High Deductible Plan
- Your spouse does not have a Healthcare Flexible Spending Account or Health Reimbursement Account
- You are not eligible to be claimed as a dependent on someone else's tax return
- You are not enrolled in Medicare or TRICARE
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care*

* Service-related care will not be taken into consideration

How an FSA Works

FIRST, YOUR FSA IS FUNDED

During Annual Enrollment (or if you have a Qualifying Life Event) you decide how much you want to contribute each plan year (January 1 through December 31), up to the annual IRS limit. Your annual contribution is divided into equal deductions and taken from your paycheck. The entire amount you elect to contribute for the year is credited to your account and available to use at the beginning of the year.

2025 IRS FSA Funding Limit Up to $3,300*

* At the time of publication of this document, the 2025 limit has not been released. This is a projected amount. If the actual 2025 limit varies, PF Holdings will honor the IRS amount.

THEN, YOU CAN USE IT TO PAY FOR CARE

You can use your FSA to pay for eligible out-of-pocket expenses for you and tax-dependent family members by:

1. **Swiping your debit card.** You'll receive a debit card from Your Flex Benefits after you open your FSA, which you can use for direct payment at a doctor's office, pharmacy, or other healthcare facility. Your debit card can also be used to pay a bill you receive in the mail from a doctor's office or facility.
2. **Reimbursing yourself.** You don't have to pay with your Healthcare FSA. You can pay with a different method, if you choose. The deadline to submit claims from the previous year (January 1 through December 31) is March 15. You can also submit claims, manage your account, and track your payments through the "Your Flex Benefits" Mobile App*.

* If you are enrolling in a spending and savings account for the first time, you will receive app login information in your welcome communication.

If you don't use all of your Healthcare FSA balance by the end of the year, you can carry over up to $640 of your unused funds to the next year, if you re-enroll in this benefit.

How an HSA Works

FIRST, YOUR HSA IS FUNDED

You contribute funds to your HSA from your paycheck. Each year, the IRS places a limit on the maximum amount that can be contributed to HSAs.

2025 IRS HSA Funding Limits
Employee: $4,300
Family: $8,550

If age 55 or over: An additional $1,000 in personal contributions is allowed.

THEN, YOU CAN USE IT TO PAY FOR CARE

You can use your HSA to pay for eligible out-of-pocket expenses for you and tax-dependent family members by:

1. **Swiping your debit card.** You'll receive a debit card from Your Flex Benefits after you open your HSA, which you can use for direct payment at a doctor's office, pharmacy, or other healthcare facility. Your debit card can also be used to pay a bill you receive in the mail from a doctor's office or facility.
2. **Reimbursing yourself.** You don't have to pay with your HSA. You can pay with a different method, if you choose. When you reimburse yourself it is completely up to you – there is no time limit as long as the claims are incurred after your HSA is opened. You can also submit claims, manage your account, and track your payments through the "Your Flex Benefits" Mobile App*.

* If you are enrolling in a spending and savings account for the first time, you will receive app login information in your welcome communication.

Comparing the Healthcare FSA and the HSA

The Healthcare Flexible Spending Account (FSA) and Health Savings Account (HSA) are two ways to save pre-tax money to pay for your eligible healthcare costs. But how do you know which one is right for you?

	Healthcare FSA	HSA
Ownership	The FSA is owned by PF Holdings. If you leave PF Holdings, you lose access to the account unless you have a COBRA right.	The HSA is an account owned by you. It is a savings account in your name and you always have access to the funds, even if you leave PF Holdings or are no longer enrolled in the High Deductible Plan.
Eligibility & Enrollment	PF Holdings determines eligibility for an FSA. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event.	You must be enrolled in the High Deductible Plan to be eligible to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible Plan or enrolled in Medicare or TRICARE. You can change your contribution at any time during the Plan Year.
Taxation	Contributions are tax-free via paycheck deduction.	The money in the account is "triple tax-free," meaning: 1. Contributions are tax-free. 2. The account grows tax-free. 3. Funds are spent tax-free (if used for qualified expenses).
Contributions	The contribution limit for 2025 is $3,300*.	The contribution limit for 2025 is $4,300 for individuals and $8,550 for families. If you are 55 or older, you may make a "catch-up" contribution of $1,000 per year.
Payment	You can use your FSA debit card to pay for eligible expenses. You can also pay up front and get reimbursed from the account. You must submit your receipts for reimbursement.	You may use your HSA debit card to pay for qualified expenses directly. or reimburse yourself later to pay for qualified expenses. You decide when and if you should use the money in your HSA to pay for qualified expenses, or if you want to use another account to pay for services and save the money in your HSA for future qualified expenses or retirement.
Roll Over or Grace Period	If you don't use all of your Healthcare FSA balance by the end of the year, you can carry over up to $640* of your unused funds to the next year, if you re-enroll in this benefit.	The money in the account rolls over from year to year. Funds are always yours and may be used for future qualified expenses.
Qualified Expenses	Physician services, hospital services, prescriptions, dental care, and vision care. A full listing of eligible expenses is available at www.irs.gov.	Physician services, hospital services, prescriptions, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full listing of eligible expenses is available at www.irs.gov.

* At the time of publication of this document, the 2025 limit has not been released. This is a projected amount. If the actual 2025 limit varies, PF Holdings will honor the IRS amount.

Please refer to your Summary Plan Description or plan certificate for your plan's specific FSA or HSA benefits.

Supplementing Your Medical Plan

Accident, Critical Illness, and Hospital Indemnity Insurances give you money to help pay out-of-pocket costs from your medical plan – such as copays, deductibles, and coinsurance – and other medical or living expenses. These plans are administered by MetLife and pay cash benefits directly to you **to spend as you choose**. Plus, when you enroll in Critical Illness and/or Accident Insurance, you and your covered spouse can also earn a $75 wellness benefit (Critical Illness) and/or $50 (Accident Insurance) each year by completing a health screening test, such as a mammogram, chest X-ray, blood test, or colonoscopy.

This chart shows what expenses are covered by each type of supplemental insurance.

Insurance Type	Accident Insurance	Critical Illness Insurance	Hospital Indemnity Insurance
Covers expenses related to...	▪ Fractures ▪ Dislocations ▪ Burns ▪ Concussions ▪ Emergency room and urgent care visits ▪ X-rays ▪ Hospitalizations	▪ Cancer ▪ Heart disease ▪ Heart attack ▪ Stroke ▪ Major organ transplant	▪ Ambulance transportation ▪ Inpatient hospital stay (including birth) ▪ Surgery

Supplemental Coverage Rates (per paycheck)

	Accident Insurance	Critical Illness Insurance	Hospital Indemnity Insurance
Employee Only	$3.84	Rates are based on your age and the amount of coverage selected.	$6.04
Employee + Spouse	$7.68		$23.69
Employee + Child(ren)	$9.38		$12.00
Employee + Family	$11.02		$29.66

Dental Benefits

Healthy teeth and gums are important to your overall wellbeing, and our dental plans administered by MetLife can help you maintain your dental health.

With both plans, preventive care – such as cleanings and x-rays – is covered at no cost to you, and you are covered for basic dental treatments when you use an in-network dentist. You may consider the Buy-Up Plan for lower annual deductibles and if you're interested in adult orthodontia coverage.

You will not receive an ID card in the mail for this benefit. Simply provide your name and SSN or Date of Birth and let them know you are with MetLife, and they will be able to find your coverage in the system.

The chart below gives a summary of the 2025 dental coverage, including what you'll pay out of your paycheck.

	Base Plan (PDP Plus Network)		Buy-Up Plan (PDP Plus Network)	
Bi-Weekly Contributions				
Employee Only	$12.51		$15.43	
Employee + Spouse	$24.89		$30.73	
Employee + Child(ren)	$26.81		$33.09	
Employee + Family	$41.86		$51.67	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible				
	Calendar Year (January 1 - December 31)		**Calendar Year (January 1 - December 31)**	
Individual	$75	$75	$25	$25
Family	$225	$225	$75	$75
Annual Maximum				
Per Person	$1,500	$1,500	$2,000	$2,000
Copays/Coinsurance				
Preventive Services	100%; deductible waived	100%; deductible waived	100%; deductible waived	100%; deductible waived
Basic Services	80%*	80%*	80%*	80%*
Major Services	50%*	50%*	50%*	50%*
Orthodontics	50%; deductible waived	50%; deductible waived	50%; deductible waived	50%; deductible waived
Orthodontics Coverage	Child(ren) Only (to age 19)		Adults and Child(ren)	
Orthodontic Lifetime Maximum	$1,000	$1,000	$2,000	$2,000

* After Deductible

** Out-of-Network care is subject to Reasonable and Customary limitations, and you are responsible for any additional charges. Reasonable and Customary charges are based on what providers in the area usually charge for the same or similar dental service.

Vision Benefits

To help you keep your vision strong and eyes healthy, PF Holdings offers you a vision plan through MetLife that covers annual exams and correction treatment. Your vision plan saves you money on eligible vision care expenses such as eye exams, glasses, and contact lenses.

You will not receive an ID card in the mail for this benefit. Simply provide your name and SSN or Date of Birth and let them know you are with Superior Vision, and they will be able to find your coverage in the system.

The chart below gives a summary of the 2025 vision coverage, including what you'll pay out of your paycheck.

	Vision Plan (Superior Network)	
Bi-Weekly Contributions		
Employee Only	$3.37	
Employee + Spouse	$6.74	
Employee + Child(ren)	$7.90	
Employee + Family	$12.12	
	In-Network	**Out-of-Network**
Copays		
Examination	$10 copay	Up to $45 allowance
Materials	$10 copay	N/A
Covered Materials		
Lenses		
Single Vision Lenses	$10 copay	Up to $30 allowance
Bifocal Lenses	$10 copay	Up to $50 allowance
Trifocal Lenses	$10 copay	Up to $65 allowance
Frames		
Retail Frame	$150 allowance plus a 20% discount on coverage after $10 copay	Up to $70 allowance
Contact Lenses		
Contact Lenses	$150 allowance after $10 copay	Up to $105 allowance
Benefit Frequency		
Examination	Once per calendar year	
Lenses	Twice per calendar year*	
Frames	Twice per calendar year*	
Contacts (in lieu of Lenses and Frames)	Twice per calendar year	

* Benefit provides for two (2) complete orders for eyewear. Eyewear purchases must be separate; allowances cannot be combined for a single eyewear purchase.

Second Pair Glasses/Contacts Benefit

This benefit gives you additional eyewear coverage! You can get:

- Two pairs of prescription eyeglasses, or
- One pair of prescription eyeglasses and an allowance toward contact lenses, or
- Double your contact lens allowance

Survivor Benefits

It's important to have a plan in place to provide for your family if something were to happen to you. Survivor benefits (Life and Accidental Death & Dismemberment (AD&D) insurance), administered by MetLife, provide financial protection in the event of an unexpected event.

Life insurance

PF Holdings provides basic employee life and AD&D insurance at no cost to you. The coverage provides a benefit equal to two times your base pay, up to $1,000,000.

You may also purchase additional optional life and AD&D insurance coverage for yourself, your spouse, and child(ren):

Plan	Details
Employee Term Life*	Elect in $10,000 increments, up to the lesser of 5 times your salary or $500,000. Guaranteed Issue Amount: $400,000
Employee AD&D**	Elect in $10,000 increments, up to the lesser of 5 times your salary or $500,000. Guaranteed Issue Amount: $400,000
Spouse Term Life	Elect in $5,000 increments, up to $500,000, not to exceed 100% of employee coverage. Guaranteed Issue Amount: $50,000
Child Term Life***	Elect in $2,000 increments, up to $10,000 Coverage may continue up to age 26. Guaranteed Issue Amount: $10,000

* Benefit reduction due to age may apply. Review plan documents for additional details.

** You may elect Optional AD&D coverage for yourself, or for yourself and your family. If Family AD&D is elected, dependent coverage is a portion of employee coverage and all of your eligible dependents are covered under one rate. No EOI is required for Optional AD&D coverage.

*** All eligible children are covered for Child Term Life.

This coverage is tied to your employment and typically ends if you leave PF Holdings. However, you may be offered the opportunity to retain coverage on your own with the same insurance carrier.

Evidence of Insurability (EOI)

Life insurance amounts over guaranteed issue coverage may require a statement of health and approval from the insurance carrier. After electing coverage, you will receive more information about an EOI, if applicable.

Note: If you are increasing coverage for Annual Enrollment or are newly electing coverage but had the option to elect previously, you may be subject to Evidence of Insurability (EOI).

Have You Named a Beneficiary?

It's important to designate a beneficiary for your life insurance benefits and to keep that information up-to-date. Even if you waive additional life insurance coverage, you should still designate a beneficiary during the enrollment process (or in the Benefits Enrollment Portal) for the basic coverage paid for by PF Holdings.

Voluntary Life Insurance			
Rates/$1,000 (per paycheck)			
Employee Age (as of 1/1/2025)	**Employee**	**Spouse Age (as of 1/1/2025)**	**Spouse**
<25	$0.033	<25	$0.034
25-29	$0.044	25-29	$0.039
30-34	$0.066	30-34	$0.049
35-39	$0.105	35-39	$0.072
40-44	$0.143	40-44	$0.103
45-49	$0.176	45-49	$0.160
50-54	$0.292	50-54	$0.250
55-59	$0.506	55-59	$0.384
60-64	$0.776	60-64	$0.655
65-69	$1.309	65-69	$1.119
70-74	$1.309	70-74	$1.993
75-79	$1.309	75-79	$1.993
80+	$1.309	80+	$1.993

Voluntary Child Life Insurance	
Rates/$1,000 (per paycheck)	
Child(ren)	$0.216

Voluntary AD&D Insurance	
Rates/$1,000 (per paycheck)	
Employee	$0.025
Employee + Family	$0.0295

To calculate how much your voluntary life coverage will cost:				
$200,000	÷ 1,000 =	$200	x Age Based Rate =	$28.60
Benefit Elected (employee)			Age 42: $0.143	Bi-Weekly Premium

Income Protection

If you get sick or suffer an injury that leaves you disabled and unable to perform your job, PF Holdings offers disability benefits through MetLife to protect you financially.

Short Term Disability (employer paid)

Our Short Term Disability benefit will be provided at no cost to you, and 60% of your salary (up to $1,250 per week) will be paid up to 13 weeks after your accident, illness, or birth of a child (if approved by MetLife).

Benefit Provided	60% of your salary
Maximum Benefit Amount	$1,250 per week
Maximum Benefit Period (including waiting period)	13 weeks (7 day waiting period + 12 week benefit period)
Waiting Period	7 days

Optional Long Term Disability (employee paid)

You have the option to elect long-term disability coverage to continue a portion of your salary if your illness or disability continues after 13 weeks. You must elect LTD during Annual Enrollment or later in the year if you have a qualifying life event. Please note late enrollment may require evidence of insurability (EOI).

Benefit Provided	60% of your salary
Maximum Benefit Amount	$10,000 per month
Maximum Benefit Period (including waiting period)	Until you no longer meet the definition of disability or reach the maximum benefit duration as defined by the policy
Waiting Period	90 days

Additional Benefits

PF Holdings provides access to a variety of additional programs that can help you save money and provide assistance with everyday needs. For more details about these benefits, log on to the Benefits Enrollment Portal via Workday, go to the three lines in the top right corner and select Documents.

Get All-Around Support

EMPLOYEE ASSISTANCE PROGRAM (EAP)

For whatever you are facing in your work, personal, or family life, the EAP through TELUS Health (via MetLife) provides support. You or your family members can speak with a counselor about a variety of concerns, including:

- Relationship issues
- Workplace transitions
- Depression
- Anxiety
- Grief

You can also use the EAP to help you with a wide range of work/life, legal, and financial services to help tackle your to-do list, such as:

- Arranging child or elder care
- Creating a budget
- Managing your health

Consultants are available 24/7, 365 days/year to provide telephonic and virtual support, as well as referrals to local providers. You and your family members can receive up to **five EAP sessions (per issue, per year) at no cost to you**.

Protect Your Rights

IDENTITY THEFT PROTECTION

Identity theft protection through NortonLifeLock™ not only monitors your identity and credit, but also provides full identity restoration in the event your identity is stolen. Plan benefits include:

- Identity, financial account, and credit monitoring
- Device security (antivirus, malware, ransomware, and hacking protection)
- Online privacy monitoring
- Up to $1 million in identity theft expense reimbursement

	Identity Theft Protection
Bi-Weekly Contributions	
Employee Only	$3.99
Employee + Family	$7.49

Legal Plan

The legal plan through ARAG provides access to a nationwide attorney network for legal advice or services, including:

- Wills and estate planning
- Family law (name change, adoption, divorce)
- Consumer protection (auto repair, consumer fraud)
- Juvenile court matters (includes criminal matters)
- Debt and identity theft matters (bankruptcy, tax audits)
- Home and real estate matters (purchase or sale of a home, security deposits)
- Divorce, dissolution and annulment – 30 hour maximum for the plan member only

There are no copays, claim forms, or deductibles for covered services.

	Legal Plan
Bi-Weekly Contributions Employee Only	$9.12

Make Your Dollars Count

AUTO/HOME INSURANCE

PF Holdings provides you access to discounted Auto and Homeowners insurance through Farmers GroupSelect℠ Insurance. Your coverage will belong to you and stay with you, even if you leave the company, so you can always take advantage of low rates. Homeowners insurance includes coverage for your house, condo, or rental property. Auto insurance includes coverage for your automobile, boat, motor home or recreational vehicle.

You can enroll in Auto/Home Insurance at any time (even outside of Annual Enrollment)!

Take Care of Your Family

ADOPTION ASSISTANCE

If you are welcoming a new child through adoption in 2025, PF Holdings will help cover expenses such as court fees, agency fees, and foreign adoption fees, up to a lifetime maximum of $10,000.

PET INSURANCE

PF Holdings knows that pets are valued members of the family. This insurance through Nationwide covers everything from preventive care to accidents or illness, including costs of x-rays, office visits, medications, surgeries, and hospital stays. You have the option of choosing your own vet or using a licensed in-network vet. Cost depends on your pet's age, species and coverage level selected.

You can enroll in Pet Insurance at any time (even outside of Annual Enrollment)!

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)

A Dependent Care FSA allows you to make pre-tax paycheck contributions up to $5,000 per year to pay for childcare expenses, such as licensed nursery schools, before- and after-school care, day camps, or caregiving services. The Dependent Care FSA is not intended to help you pay for your child's healthcare.

You can use the Dependent Care FSA because:

- Both you and your spouse work
- Your spouse goes to school full time
- Your spouse isn't physically or mentally able to care for himself or herself

Note: To receive reimbursement of dependent day care expenses, your dependent must be qualified by IRS rules.

Just like a Healthcare FSA, you make your Dependent Care FSA election during Annual Enrollment each year. You should estimate your expenses carefully, because **unused funds do not carry over at the end of the year** and are forfeited.

CHILDBIRTH RECOVERY LEAVE

Birth mothers can now have an extra four weeks of 100%-paid time off after Short Term Disability ends in order to continue to heal and recover from childbirth. For more information, please contact benefits@profrac.com.

Retirement Benefits

It's never too early – or too late – to start planning for your retirement. Making contributions to a 401(k) account is the first step toward achieving financial security later in life. The PF Holdings 401(k) plan, administered by Fidelity, provides you with the tools and flexibility you need to retire comfortably and securely.

Eligibility

You are eligible to begin participating the first of the month following three months of service. You must also be at least 18 years of age to be eligible. Non-resident aliens or leased employees are excluded from participating in the plan. (See plan document for details on excluded employees.)

Contributing to the Plan

You may defer up to 100% of your compensation or the maximum allowed by law on a pre-tax OR Roth after-tax basis. In 2024, the maximum you can contribute to the Plan is $23,000*, but if you are 50 years old or older, you may contribute an additional $7,500. In 2025, if you are between ages 60 - 63, you can contribute up to $11,250 for the catch-up.

* At the time of publication of this document, the 2025 limit has not been released.

- **Company contributions:** PF Holdings currently matches $1 for $1 up to 4% after you complete one year of service.
- **Vesting:** Your contributions are always 100% vested. Future employer contributions (including matching contributions) will be vested as follows:

Years of Service	Percentage Vested
1 Year	0%
2 Years	33%
3 Years	66%
4 Years	100%

Changing or Stopping Your Contributions

You may change the amount of your contributions any time through Fidelity's website – 401k.com. All changes will become effective as soon as administratively feasible and will remain in effect until you modify them. You may also discontinue your contributions any time. If you stop making contributions, you may start again at any time.

Distributions and Withdrawals:

Funds may be withdrawn only in the event of:

- Retirement
- Death
- Disability
- In-service at age 59½ years of age
- Termination of employment

Distributions made prior to age 59½ may be subject to a 10% excise tax if not rolled into a new qualified plan or an IRA. In the event of death, your beneficiary will receive 100% of your investment account balance.

Loans

PF Holdings allows 401(k) loans. Loans are not considered distributions and are not subject to federal or state income taxes, provided they are repaid as required. Loans are subject to regulatory criteria and provisions. For additional details, contact Fidelity at 800-835-5097, refer to your 401(k) Plan Document, contact the Benefits Department or log on to www.401k.com.

Hardship Withdrawals

Hardship withdrawals are permitted. To request a hardship withdrawal, please contact Fidelity at 800-835-5097. Fidelity customer service representatives are available 7:30 am – 7 pm CT.

Investment Options

A wide variety of investment options are available to you. Contributions may be divided in whole percentages among the investment options offered in the plan.

Investment Changes

Transfers between investments and changes to future allocations may be made by calling Fidelity at 800-835-5097. Some restrictions may apply.

Communications

In addition to account access online, you will receive an easy-to-read quarterly retirement account statement with your account details.

Company Holidays

PF Holdings provides the following paid holidays each year.

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Friday after Thanksgiving Day
- Christmas Day

Important Contacts

You'll find many details about the PF Holdings benefit plans on the Aptia365 website. However, refer to this table if you need to contact a benefit provider directly. Please note that some websites and phone numbers may not be accessible until your benefits take effect.

Benefit	Administrator	Phone Number	Website	App
Enrollment Support	Aptia365	855-200-8195	Workday.profrac.com > Announcements > Benefits Information > Benefits Enrollment Portal	Workday (code: FTSI)
Medical	BlueCross BlueShield of Texas	800-445-2227	bcbstx.com	BCBSTX
Pharmacy	CVS Caremark	866-776-5669	caremark.com	Caremark
Spending and Savings Accounts	Aptia365	855-200-8195	yourflexbenefits.aptia365.com	Your Flex Benefits
Supplemental Medical (Accident, Critical Illness, Hospital Indemnity)	MetLife	800-438-6388	metlife.com/mybenefits	MetLife
Aptia365 HUB	Aptia365	855-200-8195	Workday.profrac.com > Announcements > Benefits Information > Benefits Enrollment Portal	N/A
Dental	MetLife	800-438-6388	metlife.com/mybenefits	MetLife
Vision	Superior Vision by MetLife	833-393-5433	metlife.com/mybenefits	MetLife
Term Life/AD&D	MetLife	800-438-6388	metlife.com/mybenefits	MetLife
Disability	MetLife	833-622-0135	metlife.com/mybenefits	MetLife
Employee Assistance Program	TELUS Health (via MetLife)	888-319-7819	one.telushealth.com Username: metlifeeap Password: eap	TELUS Health One
Identity Theft	NortonLifeLock	800-607-9174	norton.com/BenefitPremier	LifeLock Identity
Legal Plan	ARAG	800-247-4184	ARAGlegal.com/myinfo (enter code 19109pf)	ARAG Legal
Auto/Home	Farmers GroupSelect	800-438-6381	myautohome.farmers.com	N/A
Pet Insurance	Nationwide Pet	844-208-1108	benefits.petinsurance.com/pfholdings	N/A
401(k)/Retirement	Fidelity	800-835-5097	401k.com	NetBenefits

Legal Notices

PF Holdings reserves the right to change, amend or terminate any benefits plan at any time for any reason. Participation in a benefits plan is not a promise or guarantee of future employment. Receipt of benefits documents does not constitute eligibility.

SUMMARY OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) or Summary of Material Reductions (SMR), as applicable, to the PF Holdings Health & Welfare Benefit Plan summary plan description (SPD). It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

SUMMARY OF BENEFITS COVERAGE

A Summary of Benefits Coverage (SBC) is available for each of the employer-sponsored medical plans at pfhcbenefits.com. You may also request a paper copy by calling Aptia365 at 866-268-0142.

TAXATION OF BENEFITS

The taxation of certain benefits may vary at the local, state and federal level. You should consult your tax advisor if you have any questions about the proper treatment of any benefits.

IMPORTANT NOTICE FROM PF HOLDINGS ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage listed below under the PF Holdings medical plans is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2025. This is known as "creditable coverage."

Why this is important: If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2025 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty — as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with PF Holdings and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

NOTICE OF CREDITABLE COVERAGE

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium. Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the PF Holdings prescription drug plans listed below, you'll be interested to know that the prescription drug coverage under the plan is, on average, at least as good as standard Medicare prescription drug coverage for 2025. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

- Blue Cross Blue Shield of TX PPO Plan
- Blue Cross Blue Shield TX High Deductible Plan

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the PF Holdings plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop PF Holdings coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the PF Holdings plan, assuming you remain eligible.

You should know that if you waive or leave coverage with PF Holdings and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In

addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this PF Holdings coverage changes, or upon your request.

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. Medicare participants 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. Here's how to get more information about Medicare prescription drug plans:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number) or visit the program online at https://www.shiptacenter.org.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

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

Benefits Department
PF Holdings
333 Shops Blvd., Suite 301
Willow Park, TX 76087
benefits@profrac.com

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) SPECIAL ENROLLMENT NOTICE

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR HEALTH PLAN COVERAGE

If you have declined enrollment in PF Holdings' health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under these plans without waiting for the next Open Enrollment period, provided you request enrollment within 31 days after your other coverage ends.

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 eligible dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

PF Holdings will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 31 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the PF Holdings group health plan. Note that this 60-day extension does not apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for special enrollment rights, you may add the dependent to your current coverage or change to another medical plan.

To request a HIPAA special enrollment based on the events described above or obtain more information, contact Benefits Department at benefits@profrac.com.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). 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 lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your medical carrier at the phone number listed on the back of your ID card.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your medical carrier at the phone number listed on the back of your ID card.

MICHELLE'S LAW NOTICE

EXTENDED DEPENDENT MEDICAL COVERAGE DURING STUDENT MEDICAL LEAVES

The PF Holdings plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from a post-secondary educational institution (including a college or university). Coverage may continue for up to a year, unless the child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary, and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If the coverage provided by the plan is changed during this one-year period, the plan will provide the changed coverage for the remainder of the leave of absence.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, call Aptia365 at 866-268-0142 as soon as the need for the leave is recognized by PF Holdings. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

FIXED INDEMNITY PLAN NOTICE — HOSPITAL INDEMNITY PLAN

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your state Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."

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

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, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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+)	**FLORIDA – Medicaid**
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – 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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
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 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK - Medicid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742 or 1-866-614-6005	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA –7858455 Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427`	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 1-833-522-5582 TDD: 1-888-221-1590
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2024, 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
OMB Control Number 1210-0137 (expires 1/31/2026)

PF HOLDINGS HIPAA PRIVACY NOTICE

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by PF Holdings health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium or as an oral communication. This notice describes the privacy practices of these plans: Blue Cross Blue Shield of TX PPO and High Deductible Health Plan. The plans covered by this notice may share health information with each other to carry out treatment, payment or healthcare operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

THE PLAN'S DUTIES WITH RESPECT TO HEALTH INFORMATION ABOUT YOU

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. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not PF Holdings as an employer — that's the way the HIPAA rules work. Different policies may apply to other PF Holdings programs or to data unrelated to the Plan.

HOW THE PLAN MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of healthcare treatment, payment activities and healthcare operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing healthcare by one or more healthcare providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for healthcare. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Healthcare operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service and internal grievance resolution. Healthcare operations also include evaluating vendors; engaging in credentialing, training and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses Personal Health Information (PHI) for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

HOW THE PLAN MAY SHARE YOUR HEALTH INFORMATION WITH PF HOLDINGS

The Plan, or its health insurer or Health Maintenance Organization (HMO), may disclose your health information without your written authorization to PF Holdings for plan administration purposes. PF Holdings may need your health information to administer benefits under the Plan. PF Holdings agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Human Resources and IT are the only PF Holdings employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and PF Holdings, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to PF Holdings, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to PF Holdings information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that PF Holdings cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by PF Holdings from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative. The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

- **Workers' compensation:** Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
- **Necessary to prevent serious threat to health or safety:** Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
- **Public health activities:** Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
- **Victims of abuse, neglect, or domestic violence:** Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
- **Judicial and administrative proceedings:** Disclosures in response to a court or administrative order, subpoena, discovery request or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
- **Law enforcement purposes:** Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
- **Decedents:** Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
- **Organ, eye or tissue donation:** Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
- **Research purposes:** Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
- **Health oversight activities:** Disclosures to health agencies for activities authorized by law (audits, inspections, investigations or licensing actions) for oversight of the healthcare system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
- **Specialized government functions:** Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
- **HHS investigations:** Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the Contact section at the end of this notice for information on how to submit requests.

RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION AND THE PLAN'S RIGHT TO REFUSE

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or healthcare operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your healthcare provider) or its business associate must comply with your request that health information regarding a specific healthcare item or service not be disclosed to the Plan for purposes of payment or healthcare operations if you have paid out of pocket and in full for the item or service.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF YOUR HEALTH INFORMATION

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a healthcare provider; enrollment, payment, claims adjudication and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested.
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint.
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

RIGHT TO AMEND YOUR HEALTH INFORMATION THAT IS INACCURATE OR INCOMPLETE

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your

request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested.
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint.
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the Other Allowable Uses or Disclosures of your Health Information section earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment or healthcare operations. To you about your own health information.
- Incidental to other permitted or required disclosures.
- Where authorization was provided.
- To family members or friends involved in your care (where disclosure is permitted without authorization).
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM THE PLAN UPON REQUEST

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

CHANGES TO THE INFORMATION IN THIS NOTICE

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2025. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice.

COMPLAINTS

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact Benefits Department at benefits@profrac.com.

CONTACT

For more information on the Plan's privacy policies or your rights under HIPAA, contact the Benefits Department at benefits@profrac.com.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Note: References to the "Marketplace" in this notice refer to the federal public health insurance marketplace and not Mercer Marketplace 365+.

PART A: GENERAL INFORMATION

To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

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 9.02% for 2025 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 9.02% for 2025 of the employee's household income.

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.

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 Benefits Department at benefits@profrac.com.

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.

1. Employer Name	**Profrac Holdings II, LLC**	2. Employer Identification Number (EIN)		**87-3882169**	
3. Employer Address	**333 Shops Blvd, Suite 301**	4. Employer phone number			
6. City	**Willow Park**	6. State	**TX**	7. Zip Code	**76087**
8. Who can we contact about employee health coverage at this job?				**Benefits Department**	
9. Phone number (if different from above		10. Email address		**benefits@profrac.com**	

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

As your employer, we offer a health plan to:

- ☐ All employees.
- ☑ Some employees. Eligible employees are: Full-time employees of PF Holdings who are regularly scheduled to work at least 30 hours per week

With respect to dependents:

- ☑ We do offer coverage. Eligible dependents are: Spouse, Child(ren) (up to age 26) and Stepchild(ren) (including disabled & court ordered dependents)
- ☐ 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.