

MACH

Benefits Guide 2027

This Guide highlights the main features of the benefit plans sponsored by Mach. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. Mach reserves the right to modify, amend, or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provision will continue in effect for any period of time. This Guide serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

It should also be noted that Mach will provide certain documents related to the Mach 401k Profit Sharing Plan and the Mach Welfare Benefit Plan (collectively, the "Benefit Plans") through an electronic media (i.e. via email or hyperlink). Additional information regarding these electronic communications may be requested from the Mach Benefits Department.

This Summary of Material Modifications contains a summary in English of your plan rights and benefits under the Mach Welfare Benefit Plan. If you have difficulty understanding any part of this Summary of Material Modifications, contact the Benefits Department at **HR@machnr.com** or (405) 252-8100. Office hours are from 8 a.m. to 5 p.m. CST Monday - Friday.

Este Resumen de modificaciones importantes contiene un resumen en inglés de los derechos y beneficios de su plan en virtud del Plan de beneficios de Mach. Si tiene dificultades para comprender alguna parte de este Resumen de modificaciones importantes, comuníquese con el Departamento de Beneficios en **HR@machnr.com** (405) 252-8124. El horario de atención es de 8.00 am A 5.00 pm CST de lunes a viernes.

Welcome to Your 2027 Benefits Guide

Use this Benefits Guide to see what's new and to learn about your benefit plan options.

What's Inside

Getting Started 4

Eligibility

Enrollment

Paying for your Health Care Benefits

Benefits 7

Medical Benefits

Medical Plans

Health Savings Account (HSA)

Flexible Spending Accounts (FSAs)

Dependent Care FSA

Prescriptions

Dental

Vision

Income Protection 17

Supplemental Health Insurance

Accident

Critical Illness

Hospital Indemnity Insurance

Group Term Life and AD&D Insurance

Disability Coverage

MDLive Virtual Visits

Retirement 26

401(k) Plan

Other Benefits 27

Employee Assistance Program

Emergency Travel

Important Contacts 29

Legal Notices 30

Disclaimer: This guide provides a summary of plan highlights. This is not a binding contract. In the event of any difference between the information contained herein and the plan documents, the plan documents will supersede and control over this guide. Please consult the Summary Plan Description for information on covered charges, limitations, and exclusions.

Getting Started

ELIGIBILITY

You are eligible to enroll in Mach's benefit plans if you are a regular, full-time employee scheduled to work 30 or more hours per week.

COVERING YOUR DEPENDENTS

You may also cover your eligible dependents, including:

- Your legal spouse, if they don't have access to health insurance.
- Your eligible children up to age 26 for medical, dental, vision, and voluntary life insurance.
    - "Children" are defined as your natural children, stepchildren, legally adopted children, and children for whom you are the court-appointed legal guardian.
    - Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

If your spouse is actively employed and he/she is eligible for medical insurance through his/her employer, your spouse is not eligible for medical insurance coverage under the Mach plan. All employees must complete a Spousal Disclosure attesting that you understand Mach's policy.

This policy does not apply to the dental and vision plans.

ANNUAL OPEN ENROLLMENT

Open Enrollment occurs annually. Benefits are effective January 1 of the upcoming year. Open Enrollment gives you the opportunity to enroll in the health and welfare plans if you have previously declined coverage.

MAKING CHANGES TO COVERAGE

Once you make your benefit elections, these choices remain in effect until the next annual Open Enrollment unless you have a qualifying life event, or you or your eligible dependents become eligible for coverage through special enrollment rules.

If you have a qualifying life event, you can make certain changes during the plan year. However, you must make your enrollment change within 31 days of the event by notifying Human Resources. If you do not notify Human Resources within 31 days, you will have to wait until the next Open Enrollment to make new elections.

Qualifying life events include, but are not limited to: change in number of dependents due to birth, adoption, placement for adoption, or death, change in legal marital status, including marriage, divorce, or death of a spouse change in employment status for you, your spouse, or your children, and more. For a more complete list of qualifying life events, refer to the Summary Plan Description.

If you have a qualifying life event or a special enrollment event and want to enroll for health coverage, contact Human Resources at ***HR@machnr.com***.

SPECIAL ENROLLMENT RULES

If you choose not to enroll yourself or your dependents because you have other coverage, you may be able to enroll yourself or your dependents at a later date IF:

- You or your dependents lose Medicaid or Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage, or
- If you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must enroll within 60 days of the qualified events listed above. If your dependent had other health coverage and lost that coverage in the above situations, they may be added to your coverage. However, you will not be able to add yourself or your dependents if the other coverage was terminated "for cause" (including failure to pay the required premiums on time).

ENROLLMENT

When you first join Mach, you have 31 days to enroll yourself and your dependents for benefits.

- Coverage begins on the first of the month following your date of hire (if your date of hire is the first of the month, your coverage is effective immediately).
- If you do not enroll within 31 days of becoming eligible, you will automatically be enrolled in company-sponsored benefits, such as Basic Life and Accidental Death & Dismemberment (AD&D) Insurance, but you will have to wait until the next annual Open Enrollment to enroll for other benefits and make changes to coverage.

PAYING FOR YOUR HEALTH CARE BENEFITS

Mach pays a portion of the total premium cost for your medical, dental, and vision benefits. The amount you pay depends on the coverage you elect and who you choose to cover.

$1,350 DEDUCTIBLE PLAN					
Advantage PPO Plan Blue Advantage Network	Total Monthly	Mach Monthly	Employee Monthly	Mach Semi-Monthly	Employee Semi-Monthly
Employee Only	$846.46	$728.12	$118.34	$364.06	$59.17
Employee & Spouse	$1,636.22	$1,169.87	$466.35	$584.93	$233.18
Employee & Child(ren)	$1,570.17	$1,219.21	$350.96	$609.61	$175.48
Employee & Family	$2,429.35	$1,712.25	$717.10	$856.12	$358.55

$1,100 DEDUCTIBLE PLAN					
Preferred PPO Plan Blue Preferred Network	Total Monthly	Mach Monthly	Employee Monthly	Mach Semi-Monthly	Employee Semi-Monthly
Employee Only	$972.94	$754.57	$218.37	$377.29	$109.18
Employee & Spouse	$1,880.72	$1,209.88	$670.84	$604.94	$335.42
Employee & Child(ren)	$1,804.80	$1,253.98	$550.82	$626.99	$275.41
Employee & Family	$2,792.36	$1,761.15	$1,031.21	$880.58	$515.60

$5,100 DEDUCTIBLE PLAN					
Preferred HDHP Plan with Health Savings Account* Blue Preferred Network	Total Monthly	Mach Monthly	Employee Monthly	Mach Semi-Monthly	Employee Semi-Monthly
Employee Only	$719.98	$621.46	$98.52	$310.73	$49.26
Employee & Spouse	$1,391.73	$968.25	$423.48	$484.13	$211.74
Employee & Child(ren)	$1,335.56	$1,013.05	$322.51	$506.53	$161.25
Employee & Family	$2,066.35	$1,411.04	$655.31	$705.52	$327.65

*If you do not meet the IRS eligibility requirements to contribute to an HSA but want to benefit from the lower premium of the High Deductible Plan, you can elect the Preferred HDHP Plan without HSA option.

DENTAL COVERAGE					
BCBS Dental Plan	Total Monthly	Mach Monthly	Employee Monthly	Mach Semi-Monthly	Employee Semi-Monthly
Employee Only	$34.87	$25.72	$9.15	$12.86	$4.58
Employee & Spouse	$69.71	$39.46	$30.25	$19.73	$15.13
Employee & Child(ren)	$92.70	$55.81	$36.89	$27.91	$18.45
Employee & Family	$140.88	$83.84	$57.04	$41.92	$28.52

VISION COVERAGE					
VSP Vision Plan	Total Monthly	Mach Monthly	Employee Monthly	Mach Semi-Monthly	Employee Semi-Monthly
Employee Only	$13.44	$6.78	$6.67	$3.39	$3.33
Employee & Spouse	$21.50	$6.69	$14.82	$3.34	$7.41
Employee & Child(ren)	$21.94	$6.68	$15.27	$3.34	$7.63
Employee & Family	$35.38	$6.53	$28.85	$3.27	$14.43

VISION COVERAGE					
VSP Vision Plan with ProTec Safety Glasses	Total Monthly	Mach Monthly	Employee Monthly	Mach Semi-Monthly	Employee Semi-Monthly
Employee Only	$15.45	$6.63	$8.83	$3.31	$4.41
Employee & Spouse	$23.51	$6.54	$16.98	$3.27	$8.49
Employee & Child(ren)	$23.95	$6.53	$17.43	$3.26	$8.71
Employee & Family	$37.39	$6.38	$31.01	$3.19	$15.51

* ProTec Safety Glasses are for employees only. Spouses and/or dependents are not covered.

Benefits

MEDICAL BENEFITS

Mach offers three medical plan options insured through Blue Cross & Blue Shield of Oklahoma (BCBS). All options offer both in-network and out-of-network benefits, so it's important to research your preferred providers before selecting a medical plan. It is also important to consider what you will pay in premiums vs. what you will pay out-of-pocket for different services.

ADVANTAGE PPO PLAN ($1,350 DEDUCTIBLE)

This plan is available at a lower premium compared to the Preferred PPO Plan because it utilizes the Blue Advantage network, which features lower contracted rates with providers in the majority of Oklahoma. Compared to the Preferred PPO Plan, this plan offers a higher deductible and 30% coinsurance but lower out-of-pocket maximum; in addition, the office visit copays are slightly higher.

PREFERRED PPO PLAN ($1,100 DEDUCTIBLE)

This plan is available at the highest premium because it utilizes the Blue Preferred network and has the lowest deductible, 20% coinsurance, and lowest copay for office visits; however, the out-of-pocket maximum is higher compared to the Advantage PPO Plan. The Preferred PPO Plan is beneficial to employees in western Oklahoma.

PREFERRED HDHP ($5,100 DEDUCTIBLE) WITH HEALTH SAVINGS ACCOUNT (HSA)

This plan is available at the lowest premium because it has a high deductible and no copays for office visits or prescription drugs. This means that all claims are subject to the deductible. Once you've met the deductible, your remaining claims are covered 100% by the plan for the remainder of the year (as you've also met your out-of-pocket maximum).

In addition, the HDHP offers a tax-advantaged Health Savings Account (HSA). With this account, you can pay IRS eligible out-of-pocket healthcare expenses throughout the year. Mach contributes $1,000 - $2,000 annually to the HSA account (depending on your coverage tier). You can also contribute additional pre-tax dollars throughout the year over 26 pay periods.



If you do not meet the IRS eligibility requirements to contribute to an HSA but want to benefit from the lower premium on the HDHP, you can elect the HDHP without HSA plan option.

IMPORTANT NOTE

This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

These charts outline the primary services utilized under the plans. Full details of all covered services are contained in the BCBSOK Summary Plan Description (SPD) governing the plans. If there is any discrepancy between the SPD and the information described here, the SPD will govern.

ADVANTAGE PPO PLAN

MEDICAL PLAN SERVICES	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE**
Preventive Care Annual exam, immunizations, age/ gender related cancer screenings	**No Charge** 100% covered by plan	30% after deductible is met
Virtual Visit – MDLive	**No Charge** 100% covered by plan	Not covered
Primary Care Physician Office Visit	$40 copay	30% after deductible is met
Specialist Office Visit	$70 copay	30% after deductible is met
Chiropractic Office Visit*	30% after deductible is met	30% after deductible is met
Calendar Year Deductible Copays not applied	$1,350 Individual $4,050 Family	$2,700 Individual $8,100 Family
Coinsurance	30%	30% or 40%
Calendar Year Out-of-Pocket Max Annual deductible and copays	$3,000 Individual $9,000 Family	$9,000 Individual $27,000 Family
Urgent Care	$50 copay	30% after deductible is met
Emergency Care facility and physician	$500 copay + 30% after deductible is met	$500 copay + 30% after deductible is met
Ambulance Transportation	No charge	Covered at 100% of allowed amount; balance billing may apply
Diagnostic Tests (X-Ray, blood work)	No charge	30% after deductible is met
Imaging Services (MRIs, CT Scans, etc.)	30% after deductible is met	40% after deductible is met
Inpatient Facility	$200 copay + 30% after deductible is met	$300 copay + 40% after deductible is met
Inpatient Physician/Surgeon	30% after deductible is met	40% after deductible is met
Outpatient Facility	$150 copay + 30% after deductible is met	$250 copay + 40% after deductible is met
Outpatient Physician	30% after deductible is met	40% after deductible is met

*Chiropractic Visits – 25 visits per year is included in a combined visit limit maximum for occupational therapy, physical therapy, and muscle manipulations.

** Out-of-Network Services are subject to balance billing by the provider.

Blue Advantage PPO Network

To receive in-network coverage, you need to make sure your health care provider is a Blue Advantage PPO network provider. There are three easy ways to verify your provider's network status:

1. Call your doctor and ask them to confirm they are a "Blue Advantage PPO network provider."
2. Call BCBSOK at **800-942-5837.**
3. Visit **www.bcbsok.com**.

PREFERRED PPO PLAN

MEDICAL PLAN SERVICES	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE**
Preventive Care Annual exam, immunizations, age/ gender related cancer screenings	**No Charge** 100% covered by plan	30% after deductible is met
Virtual Visit – MDLive	**No Charge** 100% covered by plan	Not covered
Primary Care Physician Office Visit	$35 copay	30% after deductible is met
Specialist Office Visit	$60 copay	30% after deductible is met
Chiropractic Office Visit*	20% after deductible is met	40% after deductible is met
Calendar Year Deductible Copays not applied	$1,100 Individual $3,300 Family	$2,200 Individual $6,600 Family
Coinsurance	20%	30%
Calendar Year Out-of-Pocket Max Annual deductible and copays	$5,250 Individual $10,500 Family	$15,750 Individual $31,500 Family
Urgent Care	$50 copay	30% after deductible is met
Emergency Care facility and physician	$300 copay + 20% after deductible is met	$300 copay + 20% after deductible is met
Ambulance Transportation	No charge	Covered at 100% of allowed amount; balance billing may apply
Diagnostic Tests (X-Ray, blood work)	No charge if billed w/office visit	30% after deductible is met
Imaging Services (MRIs, CT Scans, etc.)	20% after deductible is met	30% after deductible is met
Inpatient Facility	$500 copay + 20% after deductible is met	$500 copay + 30% after deductible is met
Inpatient Physician/Surgeon	20% after deductible is met	30% after deductible is met
Outpatient Facility	$250 copay + 20% after deductible is met	$250 copay + 30% after deductible is met

*Chiropractic Visits – 25 visits per year is included in a combined visit limit maximum for occupational therapy, physical therapy, and muscle manipulations.

** Out-of-Network Services are subject to balance billing by the provider.

Blue Preferred PPO Network

To receive in-network coverage, you need to make sure your health care provider is a Blue Preferred PPO network provider. There are three easy ways to verify your provider's network status:

1. Call your doctor and ask them to confirm they are a "Blue Preferred PPO network provider."
2. Call BCBSOK at **800-942-5837.**
3. Visit **www.bcbsok.com**.

PREFERRED HDHP *WITH* OR *WITHOUT* HEALTH SAVINGS ACCOUNT (HSA)

MEDICAL PLAN SERVICES	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE**
Preventive Care Annual exam, immunizations, age/ gender related cancer screenings	**No Charge** 100% covered by plan	30% after deductible is met
Virtual Visit – MDLive	No charge after deductible is met	Not covered
Primary Care Physician Office Visit	No charge after deductible is met	30% after deductible is met
Specialist Office Visit	No charge after deductible is met	30% after deductible is met
Chiropractic Office Visit*	No charge after deductible is met	30% after deductible is met
Calendar Year Deductible Copays not applied	$5,100 Individual $10,200 Family	$10,200 Individual $20,400 Family
Coinsurance	N/A	N/A
Calendar Year Out-of-Pocket Max Annual deductible and copays	$5,100 Individual $10,200 Family	$15,300 Individual $30,600 Family
Urgent Care	No charge after deductible is met	30% after deductible is met
Emergency Care facility and physician	No charge after deductible is met	No charge after deductible is met
Ambulance Transportation	No charge after deductible is met	Covered at 100% of allowed amount; balance billing may apply
Diagnostic Tests (X-Ray, blood work)	No charge after deductible is met	30% after deductible is met
Imaging Services (MRIs, CT Scans, etc.)	No charge after deductible is met	30% after deductible is met
Inpatient Facility	No charge after deductible is met	30% after deductible is met
Inpatient Physician/Surgeon	No charge after deductible is met	30% after deductible is met
Outpatient Facility	No charge after deductible is met	30% after deductible is met
Outpatient Physician	No charge after deductible is met	30% after deductible is met

*Chiropractic Visits – 25 visits per year is included in a combined visit limit maximum for occupational therapy, physical therapy, and muscle manipulations.

** Out-of-Network Services are subject to balance billing by the provider.

Blue Preferred PPO Network

To receive in-network coverage, you need to make sure your health care provider is a Blue Preferred PPO network provider. There are three easy ways to verify your provider's network status:

1. Call your doctor and ask them to confirm they are a "Blue Preferred PPO network provider."
2. Call BCBSOK at **800-942-5837.**
3. Visit **www.bcbsok.com**.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) – HEALTH SAVINGS ACCOUNT (HSA)

If you choose not to contribute to the account, you will still receive HSA contributions from Mach. In addition to the summary provided here, please refer to the HSA materials located at mymachbenefits.com for more information in making your decision.

ADMINISTERED BY HSA BANK

A Health Savings Account (HSA) is a tax-free account that earns interest. Your contributions are pre-tax, and you can choose to make changes to those contributions at any time throughout the year.

You can pay for out-of-pocket health expenses throughout the year with the tax-free dollars you contribute to your account. You receive a debit card which you use for eligible healthcare expenses.

HSA balances roll over from year to year, allowing you to build up a balance over time to cover healthcare expenses. HSA balances are portable and are taken with you if you leave the company.

HSA CONTRIBUTIONS

Mach contributes to your HSA during the plan year on a quarterly basis. Mach's contribution amount depends on the medical plan coverage level you elect. You make contributions throughout the year over 26 pay periods and can decide the amount you want to contribute during your enrollment period. Here's a summary of what Mach and you can contribute:

Coverage Level	Total 2027 IRS Annual Contribution	Mach Annual Contribution	Your Annual Contribution
Employee Only	$4,500	$1,000	Up to $3,500
Employee & Spouse	$9,000	$2,000	Up to $7,000
Employee & Child(ren)	$9,000	$2,000	Up to $7,000
Employee & Family	$9,000	$2,000	Up to $7,000

Catch-Up HSA Contribution

If you are age 55 or older by the end of the calendar year, you can contribute an additional $1,000.

ARE YOU ELIGIBLE FOR THE HSA?

You can only participate in the HSA if you enroll in Mach's Preferred High Deductible Health Plan. In addition, you cannot contribute to an HSA if any of the following apply:

- **You are covered by another health plan, including a spouse's plan, that is not a high deductible plan.**
- **You are enrolled in Medicare (If your spouse is enrolled in Medicare, you cannot use your HSA to pay for your spouse's healthcare expenses).**
- **You receive health benefits under TRICARE.**

Flexible Spending Accounts (FSA)

Mach allows you to contribute to one or both Flexible Spending Accounts (FSAs). Our FSAs are administered by HealthEquity.

- If you elect to contribute to one or both FSAs, you choose an amount to be deducted from each of your semi-monthly paychecks and deposited into your account throughout the year.
- Your contributions are taken out of your paycheck on a pre-tax basis, so you save money. Then, when you have eligible health care or dependent care expenses, you use the account to reimburse yourself, up to your annual contribution amount.
- Expenses must be incurred during the Plan Year as an active employee to be reimbursed. Expenses must be incurred between January 1, 2027, and December 31, 2027, to be eligible for reimbursement. If you have a balance left at the end of the plan year, you can take advantage of the rollover feature and apply up to $700 to the next plan year. (Rollover applies to Health Care FSA only).
- The IRS requires you to use all money in your FSA by the end of the year or you lose it. This is called the "use it or lose it" rule. This rule applies to any funds in excess of the rollover amount.
- FSAs must be re-elected every year per the IRS regulations

HEALTH CARE FSA

You can contribute up to the annual IRS maximum through pre-tax payroll deductions. The current maximum is $3,500.

You can use the Healthcare FSA to pay for IRS eligible out-of-pocket health care expenses. Examples include, but are not limited to:

- Medical or dental deductibles
- Office visit copays or prescription drug copays
- Eyeglasses, contacts, and other vision-related expenses not covered by the vision plan
- Orthodontia expenses not covered by the dental plan
- For a complete list of eligible expenses, visit **www.HealthEquity.com**

DEPENDENT CARE FSA

You can contribute up to $7,500 per year via pre-tax payroll deductions. If you are married and you and your spouse file separate tax returns, you can contribute $3,750 each.

The Dependent Care FSA helps you pay day care expenses for your children under age 13 or for a disabled dependent. There are some special rules for participating in this account:

- The day care expenses must be required so you can work.
- If you are married, your spouse must be employed, a full-time student at least five months during the plan year, or mentally or physically disabled and unable to provide care for himself or herself.

Eligible Dependent Care Expenses

Generally, you may use the money in your Dependent Care FSA for:

- Your children under age 13 whom you claim as a dependent for tax purposes.
- Other dependents of any age who are mentally or physically disabled and whom you claim as a dependent for tax purposes (spouses and dependents age 13 and older must spend at least eight hours a day in your home if you are reimbursing yourself for services provided outside the home).

Some typical expenses eligible for reimbursement under the plan are:

- Licensed nursery school and day care centers
- Licensed day care centers for disabled dependents
- Services from a care provider over the age of 19
- Day camps and after-school care
- Adult day care facilities
- For a complete list of eligible expenses, visit **www.healthequity.com/employees**.

In some cases, a federal child-tax credit may save you more money than the Dependent Care FSA. You may want to consult a tax advisor to find which option is better for you.

Important FSA Considerations

- You may rollover your unused balance up to $700 in your Health Care FSA at the end of the plan year to pay for future expenses in another plan year.
- For the Dependent Care FSA, you may only be reimbursed up to the amount in your account at the time you file a claim. If your eligible expenses are greater than the amount in your account, the unreimbursed amount will carry over and be reimbursed after your next deposit. (For the Health Care FSA, you can be reimbursed up to the full amount you have elected to contribute for the year — even if you have not yet contributed the full amount.)
- The Health Care FSA and the Dependent Care FSA are separate accounts. You cannot use funds from one account to pay for expenses of the other. You also cannot transfer funds between the two accounts.
- If you use the Dependent Care FSA, you must provide your caregiver's Social Security number or tax ID when you file a claim for reimbursement.

PRESCRIPTION DRUG PLAN

If you enroll in the medical plan, you will automatically receive prescription drug coverage through Prime Therapeutics. You can purchase prescriptions through a local retail pharmacy, or through the mail order program for maintenance medications.

Retail Prescription Network Options

When you fill a prescription for a 30-day supply at a retail pharmacy, you can select a preferred or non-preferred pharmacy. If you select a preferred pharmacy (like Walgreens or Walmart), you will pay a lower copay amount as compared to a non-preferred provider. As an added benefit with preferred providers, you can fill a prescription for up to a 90-day supply.

Find a preferred provider pharmacy near you at **www.bcbsok.com**.

	LOW DEDUCTIBLE HEALTH PLANS Advantage PPO and Preferred PPO			HIGH DEDUCTIBLE HEALTH PLANS Preferred HDHP Plan		
	In-Network Preferred Provider	In-Network Non-Preferred Provider	Out-of-Network Provider	In-Network Preferred Provider	In-Network Non-Preferred Provider	Out-of-Network Provider
Retail Prescriptions (up to 31-day supply)						
Preferred Generic Drugs	No Charge	$10 copay	$10 copay + 20%	No charge after deductible	No charge after deductible	No charge after deductible, plus 50% additional charge
Non-Preferred Generic Drugs	$10 copay	$20 copay	$20 copay + 20%			
Preferred Brand Drugs	$50 copay	$70 copay	$70 copay + 20%			
Non-Preferred Brand Drugs	$100 copay	$120 copay	$120 copay + 20%			
Preferred Specialty Drugs	$250 copay	$250 copay	$250 copay + 50%			
Non-Preferred Specialty Drugs	$350 copay	$350 copay	$350 copay + 50%			
Mail Order Prescriptions (up to 90-day supply)						
Preferred Generic Drugs	No Charge	Not covered	Not covered	No charge after deductible	Not covered	Not covered
Non-Preferred Generic Drugs	$30 copay	Not covered	Not covered			
Preferred Brand Drugs	$150 copay	Not covered	Not covered			
Non-Preferred Brand Drugs	$300 copay	Not covered	Not covered			
Preferred Specialty Drugs	Not covered	Not covered	Not covered			
Non-Preferred Specialty Drugs	Not covered	Not covered	Not covered			

DENTAL PLAN

Our Dental Plan is administered through BCBSOK and provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays, and fillings.

The Dental PPO allows you the freedom to visit any dentist, without referrals, for all your dental care. If you receive care from one of BlueCare's preferred dentists, you'll pay less for your care. If you choose a non-preferred dentist, your share of costs will generally be higher, and you may need to file your own claims.

For a list of BlueCare's preferred dentists, go to **www.bcbsok.com**.

DENTAL BENEFITS	Participating Dentist	Out-of-Network Dentist
Annual Deductible		
Individual	$50	$75
Family	$150	$225
Annual Benefit Maximum		
(Excludes Orthodontic Services)	$1,500	$1,000
Preventive Services		
(Exams, routine cleanings 2x a year, fluoride treatments, space maintainers)	100% (Deductible waived)	80% (Deductible waived)
Basic Services		
(X-rays, fillings, sealants, denture repairs)	80% of Allowable Charge after Deductible	60% of OON Allowance after Deductible
Major Services		
(Crowns, inlays/onlays, bridges, dentures, implants)	50% of Allowable Charge after Deductible	50% of OON Allowance after Deductible
Orthodontia Services (Deductible waived)		
Adults & Children	50% $1,500 Lifetime Maximum	

The deductibles for participating and out-of-network dentist services cross apply to each other.

***NOTE:** The out-of-network dentist allowance is the amount determined by the Plan as the maximum provider charge eligible for benefits. The subscriber may be responsible for the full amount by which the actual charges of an out-of-network dentist exceed the out-of-network allowance.

VISION PLAN

Our vision plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses and contact lenses. The vision plan is administered through VSP.

If you enroll in vision coverage, you can go to any eye care provider you choose for care. However, if you choose VSP network providers, you will receive a discount on services. To find a network provider, go to **www.vsp.com**.

VISION BENEFITS	In-Network	Out-of-Network
Benefit Frequency		
Exam	Every 12 months	Every 12 months
Frames	Every 24 months	Every 24 months
Lenses	Every 12 months	Every 12 months
Contacts	Every 12 months (Instead of Lenses)	Every 12 months
Benefit Feature	**You Pay**	**Reimbursement**
Exam	$10 copay	Up to $45
Prescription Lenses	$25 copay	*See below*
Single Lenses	Included in Prescription Lenses	Up to $30
Bifocal Lenses – Lined	Included in Prescription Lenses	Up to $50
Trifocal Lenses – Lined	Included in Prescription Lenses	Up to $65
Frames	$180 allowance for a wide selection $170 allowance for featured frame brands	Up to $70
Contacts	$180 allowance (Instead of Lenses)	Up to $105
Lasik	15% average discount	N/A
ProTec Safety Glasses	**In-Network Only**	
Benefit Frequency		
Frames	Every 24 months	
Lenses	Every 12 months	
Benefit Feature	**You Pay (Employees Only)**	
Frames	$20 copay • Choose a safety frame from your VSP doctor's ProTec Eyewear collection • Certified according to ANSI guidelines for impact protection	
Lenses	Included with Frames • Prescription single vision, lined bifocal, and lined trifocal • Certified according to ANSI guidelines for impact protection	

Income Protection

SUPPLEMENTAL HEALTH PLANS

No one can predict when an accident or illness may happen, but supplemental health plans can help make sure you and your budget are prepared. Supplemental health plans pay a cash benefit that helps fill the gap with major medical insurance and provides an extra layer of financial protection for unexpected events.

These plan options include: **Accident Insurance, Critical Illness Insurance,** and **Hospital Indemnity Insurance**. Coverage is available for yourself, your spouse, and children. The following pages provide more details on each plan option and how you could benefit from having additional protection.

Health Assessment Benefit

Each supplemental health plan provides an additional Health Assessment Benefit for certain covered screenings and preventive tests. To claim your Health Assessment Benefit, simply contact Lincoln to provide details from your screening and Lincoln will mail you a check once your claim is processed. Outlined are several examples of covered screenings and tests:

- Annual physicals
- Blood tests
- Cancer screenings
- Infectious disease related screenings
- Immunizations
- Vitamin D screenings
- School or sports physicals
- Prenatal counseling
- Mental disorder and substance abuse screenings

RECEIVE A $50 CASH BENEFIT

Our plans include a $50 benefit per covered person per year.

You, your spouse, and your children are eligible – if you choose to cover them.

You can get a separate $50 benefit for each supplemental health plan you elect.

ACCIDENT INSURANCE

Accident insurance pays out a lump sum if you incur an injury due to an accident. These benefits may supplement both health and disability insurance and can be used to pay for out-of-pocket expenses or provide additional financial support if a covered event causes you to lose income due to being out of work.

In addition, benefits are available to help protect your children under the age of 26 who experience an accident during an organized sports activity. And the policy pays multiple cash benefits for each injury and covered treatment when an insured individual sustains more than one injury in the same accident.

Receive a check if a covered injury results in any of the following:

- Initial physician office visit or urgent care
- Physician follow-up visits
- Emergency Room and X-rays
- Major diagnostic exams
- Physical, occupational, and chiropractic care
- Dislocations, fractures, lacerations

Accident Rates		
	Monthly	Semi-Monthly
Employee Only	$9.47,	$4.74
Employee & Spouse	$15.77	$7.89
Employee & Child(ren)	$17.23	$8.62
Employee & Family	$23.41	$11.71

Health Assessment Benefit

Even if you and your covered family members don't have an accident, the plan provides a **$50 cash** benefit per covered person.

Commonly Covered Benefits Include	
Hospital Admission / ICU Admission	$1,000 within 180 days / $2,000 within 30 days
Hospital Confinement	$200 per day up to 365 days
ICU Confinement	$400 per day up to 15 days
Ambulance / Air Ambulance	$425 / $1,750 within 90 days
Emergency Care Treatment	$250 within 72 hours
Physician Initial Visit	$125 within 60 days
Major Diagnostic Exam (CT, MRI, PET)	$275 within 60 days
X-Ray	$225 within 60 days
Fractures (within 90 days)	$200 - $3,000 depending on covered body part
Dislocations (within 90 days)	$35 - $3,000 depending on covered body part

*For a full schedule of covered benefits, please refer to the Lincoln Financial Benefit Summary.

CRITICAL ILLNESS INSURANCE

Critical Illness insurance can help safeguard your finances by providing you with a lump-sum payment when you or your family may need it most. This lump-sum payment allows you to pay for whatever you need, such as expenses that may not be covered by your main medical plan (e.g., copays, deductibles, childcare, mortgage, groceries, and experimental treatments).

- Pays a flat benefit upon diagnosis of a covered condition.
- Pays multiple cash benefits when an insured individual has more than one condition.
- No offsets or coordination with other insurance plans.
- Employees can keep coverage if they ever leave the company.
- Spouses and children can port coverage in the event of a deceased employee.

Health Assessment Benefit

Even if you and your covered family members are not critically ill, the plan provides a **$50 cash** benefit per covered person.

Commonly Covered Benefits Include *(coverage amounts vary by condition)*	
Heart Attack	Advanced Alzheimer's Disease
Stroke	Advanced Parkinson's
Atrial/Vascular Disease	Advanced MS
Major Organ Failure	Invasive & Non-Invasive Cancer
Renal Failure	Severe Traumatic Brain Injury
Benefits	
Employee Coverage Amount	Option(s) of $10,000, $20,000, $30,000
Spouse Coverage Amount	Option(s) of $5,000, $10,000, $15,000 not to exceed 50% of the employee benefit amount
Child(ren) Coverage Amount	Option(s) of $5,000, $10,000 not to exceed 50% of the employee benefit amount
Pre-Existing Condition Limitations	No pre-existing condition limits but *condition must be diagnosed on or after the coverage effective date*.
Recurrence Period	6 months, treatment free (for the same covered condition)
Separation Period	3 months (different covered conditions; exclusions may apply)

The Critical Illness premiums you pay for employee and spouse are based on age and the coverage amount you elect; the premium for child coverage is based on the coverage amount and covers all your children. However, you may only elect coverage for your dependents if you enroll in the benefit for yourself.

EMPLOYEE COVERAGE			
	Semi-Monthly		
Attained Age	Employee $10,000	Employee $20,000	Employee $30,000
Under 24	$0.78	$1.55	$2.33
25-29	$1.08	$2.16	$3.24
30-34	$1.49	$2.98	$4.47
35-39	$2.22	$4.44	$6.66
40-44	$3.36	$6.71	$10.07
45-49	$4.89	$9.77	$14.66
50-54	$7.04	$14.07	$21.11
55-59	$9.49	$18.97	$28.46
60-64	$13.69	$27.38	$41.07
65-69	$19.46	$38.91	$58.37
70+	$32.47	$64.93	$97.40

SPOUSE COVERAGE *Cannot Exceed 50% of Employee Amount*			
	Semi-Monthly		
Attained Age	Spouse $5,000	Spouse $10,000	Spouse $15,000
Under 24	$0.39	$0.78	$1.16
25-29	$0.54	$1.08	$1.62
30-34	$0.75	$1.49	$2.24
35-39	$1.11	$2.22	$3.33
40-44	$1.68	$3.36	$5.03
45-49	$2.44	$4.89	$7.33
50-54	$3.52	$7.04	$10.55
55-59	$4.74	$9.49	$14.23
60-64	$6.85	$13.69	$20.54
65-69	$9.73	$19.46	$29.18
70+	$16.23	$32.47	$48.70

CHILD COVERAGE *Cannot Exceed 50% of Employee Amount*		
	Semi-Monthly	
	Child(ren) $5,000	Child(ren) $10,000
All Children	$0.71	$1.42

Your Health Advocate is Available 24/7

When you elect Critical Illness Insurance, this service is available to you and your family (including parents & parents-in-law), even if you are not critically ill.

Your Health Advocate can help you and your family:

- Find the right doctors
- Help in finding second opinion
- Coordinate of care among providers
- Coordinate of hospice, adult day care, and other services
- Assist in negotiating medical bills of $400 or more
- Conduct up to three in-person or video conference counseling sessions
- Unlimited telephonic counseling

HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity insurance pays you benefits when you are confined to a hospital, whether for planned or unplanned reasons, including having a baby. This benefit may supplement both health insurance and disability insurance if a covered incident causes you to have out-of-pocket expenses.

Receive a check when you or a covered family member have one of the following hospital services outlined below:

Hospital Indemnity Rates		
	Monthly	Semi-Monthly
Employee Only	$21.67	$10.84
Employee & Spouse	$46.27	$23.14
Employee & Child(ren)	$33.36	$16.68
Employee & Family	$ 60.45	$30.23

	Covered Benefits
Hospital Admission	$1,000 1 Day per calendar year for sickness/injury
Hospital Confinement	$200 per day Up to 30 days per calendar year for sickness/injury Benefit begins on day 2 of confinement
ICU Admission	$2,000 1 Day per calendar year for sickness/injury
ICU Confinement	$400 per day Up to 30 days per calendar year for sickness/injury Benefit begins on day 2 of confinement
Hospital NICU Admission	Increases the ICU admission benefit by 25% for the child
Hospital NICU Confinement	Increases the ICU confinement benefit by 25% for the child

Health Assessment Benefit

Even if you and your covered family members do not have a hospital or ICU event, the plan provides a **$50 cash** benefit per covered person.

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 are still responsible for paying the cost of your health care expenses.

- 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 does not have to include most federal consumer protections that apply to health insurance.

*For full details on covered benefits, please refer to the Benefit Summary.

GROUP TERM LIFE & AD&D INSURANCE

Basic Life & AD&D Insurance

Mach automatically provides Basic Life & AD&D Insurance for all eligible employees at no cost to you. The coverage amount is equal to 2 times your annual salary, up to a maximum benefit of $250,000 (does not include overtime or bonuses). All life and AD&D policies are insured by Lincoln Financial Group.

IRS Rules about Basic Life Coverage

If your basic life insurance coverage is more than $50,000, your income taxes may be affected. IRS regulations require that the value of life insurance benefits over $50,000 be reported as "imputed income," which is non-cash income that you receive from an employer-provided benefit. The value of any coverage that exceeds $50,000 will be reported to the IRS as imputed income on your W-2 form.

Voluntary Life & AD&D Insurance

In addition to basic life & AD&D insurance, you may also purchase Voluntary Life and AD&D insurance for yourself, your spouse, and your dependent children. However, you may only elect coverage for your dependents if you enroll for Voluntary Insurance for yourself. You pay for the cost of Voluntary Insurance on an after-tax basis through payroll deductions.

Benefits Reduce at Age 65

Life and AD&D insurance coverage are subject to age reductions. At age 65, coverage amounts reduce to 65%, at age 70, coverage amounts reduce to 50%, and at age 75 coverage amounts reduce to 35%. The reductions apply to both employee and spousal coverage.

Voluntary Life and AD&D Coverage Summary

Policyholder	Coverage Options
Employee	• **$10,000 - $300,000** (increments of $10,000) • **During Open Enrollment**, you can increase your current coverage amount an additional $20,000 without submitting Evidence of Insurability (EOI); if you elect over this amount, EOI is required. • If you are enrolling for the first time, you can elect up to $200,000 without submitting EOI; you are required to submit EOI for any amount over $200,000.
Spouse	• **$5,000 - $150,000** (increments of $5,000 up to 100% of the employee's election) • **During Open Enrollment**, you can increase your spouse's coverage amount an additional $10,000 without submitting Evidence of Insurability (EOI); if you elect over this amount, EOI is required. • If you are enrolling for the first time, you can elect up to $50,000 without submitting EOI; you are required to submit EOI for any amount over $50,000. Spouse coverage cannot exceed 100% of employee's coverage up to the maximum of $150,000 and the rate is based on the employee's age.
Child(ren)	• **$2,000 - $10,000** (increments of $2,000) • Regardless of the number of children you have, they are all covered at the same coverage amount for a combined premium through age 26. EOI is not required for child(ren).

*If required, Evidence of Insurability (EOI) must be submitted to Lincoln Financial Group to obtain approval for your election amount.

Schedule of Rates

Rates are based on the employee's age as of January 1 for both employee and spouse.

Voluntary Life Rates per Pay Period											
Age as of January 1	<29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Employee/Spouse Rate per $1,000	$0.040	$0.045	$0.050	$0.085	$0.126	$0.175	$0.290	$0.411	$0.726	$1.426	$3.252
Child Rate per $1,000 per pay period	$0.05/$1,000										

Voluntary AD&D Per Pay Period Rates			
Coverage	Employee	Spouse	Child(ren)
Rate per $1,000	$0.025	$0.025	$0.025

Employee: $_____ coverage ÷ $1,000 = _____ X $_____ (your age rate above) = $_____ (per pay period)

Spouse: $_____ coverage ÷ $1,000 = _____ X $_____ (Employee age rate above) = $_____ (per pay period)

_____ + _____ + _____ = _____

Employee Premium Spouse Premium Child(ren) Premium Total Premium per Pay Period

DISABILITY COVERAGE

Mach automatically provides disability insurance for all eligible employees at no cost to you. Our short-term disability and long-term disability plans work together to keep part of your paycheck coming if you cannot work because of illness, injury, or pregnancy. Disability benefits are insured by Lincoln Financial Group.

Short-Term Disability (STD)

STD benefits are provided by Mach to all eligible employees.

- STD benefits will replace 60% of your base pay up to a maximum of $2,500 per week.
- STD benefits begin on the 8th calendar day of your illness or post-surgery or immediately if you are involved in an accident and are unable to work.
- The maximum benefit available is 90 days per STD claim.

Long-Term Disability (LTD)

If you remain totally disabled and unable to work for more than 90 days, you may be eligible for LTD benefits.

- LTD benefits will replace 60% of your base pay, up to a maximum of $15,000 per month.
- Your monthly LTD benefit will be reduced by Social Security and any other disability income you are eligible to receive (such as Workers' Compensation).

When are you disabled?

To be considered totally disabled and eligible for benefits, you must be approved by the insurance carrier and be seeing a doctor regularly for treatment. In addition:

- Your doctor must certify that you are not able to do your job, and you must have lost 20% or more of your pre-disability income due to your illness or injury.

How are benefit plan premiums handled during disability?

While receiving disability benefits, you are responsible for payment of the employee portion of your elected benefit plan premiums to maintain benefits coverage during your leave of absence. Mach's contribution to your benefits will continue until the end of the approved leave of absence due to disability, up to a maximum of six months following the start of the leave. Thereafter, you will have an opportunity to elect COBRA continuation of coverage.

MDLIVE VIRTUAL VISITS

Getting sick is never convenient, and finding time to get to the doctor can be hard. BCBSOK provides you and your covered dependents access to care for non-emergency medical issues and behavioral health needs through **MDLIVE**.

Whether you're at home or traveling, access to a board-certified doctor is available 24 hours a day, seven days a week. You can speak to a doctor immediately or schedule an appointment based on your availability. Virtual visits can also be a better alternative than going to the emergency room or urgent care center in some instances. And it's part of your health benefits.

MDLIVE doctors or therapists can help treat the following conditions and more:

- Allergies
- Cold or flu
- Anxiety/Depression
- Asthma
- Nausea
- Sinus infections
- Ear Problems
- Pink Eye
- Marriage Problems

Website:

Visit the website **MDLIVE.com/bcbsok**

- Choose a doctor
- Video chat with the doctor
- You can also access through Blue Access for Members℠

Mobile App:

- Download the app from the Apple Store℠, Google Play™, Store or Windows® Store
- Open the app and choose a doctor
- Video chat with the doctor from your mobile device



Connect

Access where mobile app, online video, or telephone service is available



Interact

Real-time consultation with a board-certified doctor or therapist



Diagnose

Prescriptions sent electronically to a pharmacy of your choice (when appropriate)

Retirement

401(k) PLAN

Smart saving and investing is the foundation for financial security during your retirement years. Our 401(k) plan, through Empower Retirement, is designed to help you reach your retirement goals and can be a powerful tool in your secure financial future.

How the Plan Works

- Employees are eligible to participate after reaching age 21.
- Employees are eligible to participate day one of employment.
- Employees can contribute 1% to 100% of eligible compensation (please account for tax implications when determining your contribution amount).
- The IRS limits pre-tax savings to a maximum dollar amount each year. For 2027, you can contribute up to $24,500 pre-tax for those under 50 years old, and an additional $8,000 in catch up for those over 50 years old or up to the 2027 IRS maximum.

Company Contribution & Vesting

Mach matches 100% for the first ten percent (10%) contributed by the employee.

- Employee contributions are always 100% vested.
- The Employer Match is based on a 4-year vesting schedule, 25% per year.

Other Benefits

EMPLOYEE ASSISTANCE PROGRAM (EAP)

You and your covered dependents have free access to Mach's Employee Assistance Program (EAP) EmployeeConnect. The EAP is provided by Lincoln Financial Group through their partnership with GuidanceOne.

We all experience times when we need a little help managing our personal lives. Mach understands this and is providing the EAP to employees to offer support, guidance, and resources to help you and your family find the right balance between your work and home life.

Experienced member advocates – many of whom hold master's degrees within their respective disciplines – will confidentially consult with you over the telephone and direct you to the solutions and resources you need. You may also receive referrals to support groups, community resources, a network counselor, or your health plan. These services are available for covered employees, their dependents, including children to age 26, and all household members. Your beneficiaries will also be covered up to 90 days after your death.

The EAP can help with:

- Depression, grief, loss, and emotional well-being
- Family, marital, and other relationship issues
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family
- Financial and legal concerns
- Identity theft and fraud resolution
- Online will preparation

To Contact the EAP

Call: 888-628-4824
Online: GuidanceResources.com
Mobile: Download the GuidanceNow mobile app

New Users: Select "Register" and enter Web ID: LFGSupport
Follow the prompts to create your username and password.

Get support anytime, 24 hours a day, 365 days a year.

EMERGENCY TRAVEL ASSISTANCE PROGRAM

Medical problems surface at the most inconvenient times. ***TravelConnect*** can help you navigate these issues and more at any time day or night. You, your spouse, and children through age 26 are covered with ***TravelConnect*** under your Basic life insurance with Lincoln Financial Group.

TravelConnect is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including:

- Passport, visa, weather, currency exchange information, health hazards advice, and inoculation requirements.
- Emergency ticket, credit card, and passport replacement and missing baggage.
- 24/7/365 phone access to registered nurses for health and medication information, symptom decision support, and help understanding treatment options.
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains.
- Connection to medical care providers, interpreter services, a local attorney, consular office, or bail bond services.
- Return travel companion: If you have a medical emergency and need to be transported home via medical evacuation, your travel companion's trip home is covered.
- Logistical arrangements for ground transportation, housing and/or evacuation in the event of political unrest and social instability; for more complex situations, assists with making arrangements with providers of specialized security services.
- For a complete list of TravelConnect services, go to **MyOnCallPortal.com** and enter Group ID LFGTravel123.

Contact TravelConnect

Call: 866-525-1955
United States and Canada

Call Collect: 603-328-1955
Anywhere in the world

Email: mail@OnCallInternational.com

Important Contacts

VENDOR	PHONE	WEBSITE/EMAIL
Medical/Prescription & Dental Plans BCBSOK	800-942-5837	www.bcbsok.com
Health Savings Account (HSA) HSA Bank	800-357-6246	www.hsabank.com
BCBSOK Virtual Visits MDLIVE	888-970-4081	www.MDLIVE.com/bcbsok
Vision Plan VSP	800-877-7195	www.vsp.com
Flexible Spending Accounts (FSA) Health Equity	877-924-3967	www.healthequity.com
Group Term Life/AD&D Insurance **STD/LTD Disability Insurance** **Supplemental Health Plans** **Lincoln Financial Group**	888-408-7300	www.lincolnfinancial.com
Employee Assistance Program (EAP) Lincoln Financial Group (Guidance Resources)	888-628-4824	GuidanceResources.com
Travel Assistance Program Lincoln Financial Group		MyOnCallPortal.com **ID: LFGTravel123**
401(k) Plan Empower Retirement	800-338-4015	https://participant.empower-retirement.com/participant/#/login
Mach HR Department	405-252-8100	HR@machnr.com

Health Coverage Notices

Each year, Mach Natural Resources is required to provide certain legally mandated notices and disclosures relating to its benefit plans. These notices apply to Mach Natural Resources as required by federal law.

TABLE OF CONTENTS

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) 31

COBRA Rights Notice 34

Medicare Part D Notice of Creditable Coverage 38

Health Insurance Marketplace Coverage Options and Your Health Coverage 42

Your Rights and Protections Against Surprise Medical Bills 44

Privacy Notice 45

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 15 of the Legal Notices and Disclosures section for important information concerning Medicare Part D coverage.

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you have questions about enrolling in your employer plan, contact the Department of Labor at http://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, 2026. Contact your State for more information on eligibility.

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

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: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ 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	**ILLINOIS - 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	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov

INDIANA – Medicaid	IOWA – Medicaid and CHIP (Hawki)
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	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
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/ki-hipp.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
LOUISIANA – Medicaid	**MAINE – Medicaid**
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	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

MASSACHUSETTS – Medicaid and CHIP	MINNESOTA – Medicaid
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
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	Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ 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)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	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: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP	SOUTH CAROLINA – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
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/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
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	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

COBRA RIGHTS NOTICE

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATIONCOVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the

Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

- For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Notification may be provided

by contacting Mach Natural Resources HR at 405-252-8100 or HR@machnr.com.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work.

Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be

disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at sometime before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Notice of a disability determination by the 18-month Social Security Administration must be made by contacting Mach Natural Resources HR at 405-252-8100.

Notice of the disability determination must be provided within 60 days after the later of (1) the date of the disability determination by the Social Security Administration, (2) the date on which the covered employee's employment terminated or his/her hours were reduced, and (3) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the covered employee's termination of employment or reduction in work hours. This notice must also be provided no later than 18 months after the covered employee's termination of employment or reduction in work hours.

If the Plan's notification procedures are not followed or if you do not provide timely notice of the events listed, the affected qualified beneficiaries will lose their rights to extended COBRA coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part

B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is

only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event by contacting Mach Natural Resources HR at 405-252-8100.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period."

Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends? In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period1 to sign up for Medi-

care Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part

of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit

https://www.medicare.gov/medicare-and-you

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Name of Entity: Mach Natural Resources

Contact: Colby Hirn

Address: 14201 Wireless Way, Ste. 300

Oklahoma City, OK 73134

Phone Number: 405-252-8124

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Important Notice from Mach about Your Prescription Drug Coverage and Medicare

The key purpose of this notice is to advise you that the prescription drug coverage you have under your Mach prescription plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2027 (This is known as "creditable coverage.") The reason this is important is that if you or a covered dependent are or become eligible for Medicare and you decide to enroll in a Medicare prescription drug plan during a subsequent Annual Enrollment Period, you will 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.

Notice of Creditable Coverage

Please read this notice carefully. This notice has information about your current prescription drug coverage with Mach Natural Resources 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.

1. **Medicare prescription drug coverage is available to everyone with Medicare.**

2. **Mach Natural Resources has determined that the prescription drug coverage offered by each medical insurance coverage option is, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay in 2027.**

3. **Read this notice carefully - it explains the options you have under Medicare's**

   prescription drug coverage and can help you decide whether or not you want to enroll.

Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

If you are covered under one of the prescription drug plans, your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage in 2027. Therefore, if you are or become eligible for Medicare, you can keep this coverage and not pay extra if you later decide to enroll in a Medicare prescription drug plan.

Medicare participants can enroll in a Medicare prescription drug plan October 15 - December 7.

However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to keep that coverage and join a Medicare prescription drug plan later. Each year after that, you will have the opportunity to enroll in a Medicare prescription drug plan from October 15th through December 7th.

If you decide to enroll in a Medicare prescription drug plan, you may also continue your coverage under the Plan. The Plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. You may also drop your Plan coverage, in which case Medicare will be your only payer. You can re-enroll in the Plan during the Annual Enrollment Period or if you have a special enrollment event.

At this time, Mach Natural Resources is planning to continue, for 2027, its prescription drug plan offerings available to Medicare eligible individuals.

You should know that if you drop or lose your coverage with Mach Natural Resources and don't promptly enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage.

For example, if you go nineteen 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 next October to enroll. However, if you involuntarily lose creditable prescription drug coverage, you will be eligible for a two-month Special Enrollment Period (SEP) to enroll in a Part D plan.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage will be available in the "Medicare & You" handbook.

Medicare participants will get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans.

You can 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 their telephone number).
- 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 online from the Social Security Administration ("SSA") at **www.socialsecurity.gov** or call them at

  1-800-772-1213 (TTY 1-800-325-0778).

You will get this notice every year, and you will get this notice before the next period you can join a Medicare drug plan, and if this coverage through Mach Natural Resources changes. You may also request a copy of this notice at any time.

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare, which offer prescription drug coverage, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

SOCIAL SECURITY NUMBERS GENERALLY REQUIRED FOR ENROLLMENT

Under Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA"), the Centers for Medicare and Medicaid Services ("CMS") generally requires Social Security numbers for employees and dependents to assist with reporting under the Medicare Secondary Payer requirements. Accordingly, when you enroll in the Plan, you

will be required to provide Social Security numbers for yourself and any dependents you wish to enroll to assist us in complying with this requirement. If Social Security numbers are not available for any of your dependents, you should contact Mach Natural Resources HR for additional instructions.

THE FAMILY AND MEDICAL LEAVE ACT

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 ("FMLA"), you may continue to participate in and receive health coverage under the Plan during the leave if the following conditions are met:

- Your leave has been approved in writing by the employer, and
- Any required contribution for the cost of your coverage is paid by you when due.
- When you return to work, any arrears for unpaid premiums will be taken out of your paycheck.

You may continue to receive health coverage under the Plan until the end of the leave period required by the FMLA. If you cancel your coverage while you are on an approved FMLA leave and you return to work as an eligible employee immediately following your approved FMLA leave (or your approved leave of absence that includes an approved FMLA leave), you have the right to have your participation reinstated as soon as you return to work for one full day.

If you do not return to work following an approved FMLA leave you (and your spouse and dependent children, if any) may be eligible for COBRA continuation coverage as of the date you terminated employment with Mach Natural Resources. For more information, contact Mach Natural Resources HR at 405-252-8100.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 ("USERRA")

If you voluntarily or involuntarily serve in the uniformed services of the United States for a period of five years or less while an eligible employee, your and covered dependents' medical, dental and/or vision coverage may automatically continue up to 24 months, provided you or your dependents pay the cost of coverage. You may elect to terminate continued coverage at any time. For the first month, the cost is based on the active employee rate and after the first month, it is 102% of the full premium (premium plus 2% administrative fee.)

This provision applies to:

- Employees on active duty in the U.S. Armed Forces,
- Employees on active duty for training in the U.S. Armed Forces,
- Employees on initial active duty for training and inactive duty training in the U.S. Armed Forces (including the Reserve components), the Army or Air National Guard and the commissioned corps of the Public Health Service, and to full-time National Guard duty, and
- Absences needed to determine the employee's fitness for duty in the uniformed service.

If you are still on leave after 24 months, you and your dependents may be eligible to continue coverage under COBRA.

Coverage will end if you are discharged from military service under other than honorable conditions, or if you are dismissed or dropped from the rolls under conditions that result in loss of reemployment rights under the law.

If you or your dependents are covered by TRI-CARE, any plan will not coordinate benefits.

SPECIAL ENROLLMENT RIGHTS

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

LOSS OF OTHER COVERAGE

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

MARRIAGE, BIRTH OR ADOPTION

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be

able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan.

However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

FOR MORE INFORMATION OR ASSISTANCE

To request special enrollment or obtain more information, please contact: HR@machnr.com

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related benefits, coverage will be determined in a manner determined in consultation with the attending physician and the patient. This includes all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications related

to all stages of the mastectomy (including lymphedemas). These mastectomy-related benefits are subject to the same annual deductibles and coinsurance rules that apply to other medical and surgical benefits. For more information, call the medical plan carrier for which you are enrolled at the telephone number on your medical plan ID card.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

The Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child not 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 physician, after consulting with the mother, from discharging the mother and her newborn earlier than the 48 hours (or 96 hours as applicable). In any case, the Plan may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay that does not exceed 48 hours (or 96 hours).

MENTAL HEALTH PARITY

Except in limited circumstances, federal law requires that any mental health care coverage provided by a group health plan generally be comparable to the coverage available for other types of illness or disease. In particular:

- The financial requirements (e.g., deductibles and co-payments) and treatment limitations
- (e.g., number of visits or days of coverage) that apply to mental health and substance abuse benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/ surgical benefits;
- Mental health benefits and substance abuse benefits may not be subject to any separate cost-sharing requirements or treatment limitations that only apply to such benefits;
- Out-of-network mental health and substance abuse benefits must generally be made available to covered persons;
- Standards for medical-necessity determinations and reasons for any denial of benefits relating

  to mental health benefits and substance abuse benefits must be made available upon request to Plan participants; and
- The requirements imposed by the Mental Health Parity Act of 1996 (regarding annual and lifetime dollar limits) will continue and will be extended to substance abuse benefits.

In accordance with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 and its related regulations, upon request, the Plan (or the applicable insurance company) will provide a copy of any criteria used to make medical necessity determinations regarding mental health or substance abuse disorder benefits. In the event your claim for mental health or substance abuse disorder benefits is denied, the Plan or

the applicable insurance company will provide you with an explanation for the denial.

QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO")

Upon receipt of a Qualified Medical Child Support Order ("QMCSO"), Mach Natural Resources will follow its procedures established for reviewing and implementing such orders with respect to coverage under the Plan.

Upon receiving a properly completed National Medical Support Notice issued by a state child support enforcement agency (Issuing Agency), the notice shall be treated as a QMCSO. If Mach Natural Resources cannot comply with the notice for one of the permitted reasons, Mach Natural Resources will complete the Employer Response form included in Part A of the notice specifying the reason(s) that it cannot comply with the notice and advise the Issuing Agency.

If Mach Natural Resources can comply with the notice, then it will forward a copy of Part B of the notice (Plan Administrator Response form) to the Plan Administrator within 20 business days of the date of the notice. The Plan Administrator will complete the Plan Administrator Response form to inform the employer and the Issuing Agency if the notice is a QMCSO. If the notice is determined not to be a QMCSO, then the Plan Administrator will specify the reasons and notify the Issuing Agency and the affected parties of that fact. If the notice is

determined to be a QMCSO, the Plan Administrator will provide the effective date of enrollment of the child in the health care benefit program, whether any waiting periods apply and what employee contribution is necessary for coverage.

RIGHTS PURSUANT TO GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 ("GINA")

Mach Natural Resources complies with GINA and, therefore, does not:

- Increase group premium or contribution amounts based on genetic information;
- Request or require an individual or family members to undergo genetic testing; or
- Request, require or purchase genetic information prior to or in connection with enrollment or at any time for underwriting purposes.

"Genetic information" is information about (1) an individual's genetic tests; (2) the genetic tests of an individual's family members; (3) the manifestation of a disease or disorder in an individual's family members; or (4) any request or receipt by the individual of his or her family members of genetic information. Genetic information does not include blood tests that are not designed to obtain information relating to genotypes, mutations or chromosomal changes; cholesterol tests; or information about the age or sex of an individual or family member.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

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

What is the Health Insurance Marketplace?

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

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

You may qualify to save money and lower your monthly premium, 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 (as discussed below). The savings on your premium that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employer 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 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 a plan offered to you through your employment is more than 10.22% of your annual household income, or if the coverage your employer provides 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 10.22% of the employee's household income.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employment, then you may lose access to whatever the employer contributes to the employment-based coverage — is often 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.

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

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

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

To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan. Confirm the deadline with your employer or your employment-based health plan. Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Mach Natural Resources HR at HR@machnr.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.

3. Employer name Mach Natural Resources	**4. Employer Identification Number (EIN)** 81-4809861	
5. Employer address 14201 Wireless Way, Ste. 300	**6. Employer phone number** 405-252-8124	
7. City Oklahoma City	**8. State** Oklahoma	**9. ZIP Code** 73134
10. Who can we contact about employee health coverage at this job? Colby Hirn		
11. Phone number (if different from above)	**12. E-mail address** chirn@machnr.com	

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

- As your employer, we offer a health plan to some employees.

Eligible employees are:

- Active, Full-time Employees working a minimum of 30 hours per week and have met the required waiting period With respect to dependents, we do offer coverage.

Eligible dependents are:

- Your Legal Spouse

- Dependent Children up to age 26

- Dependent Children, regardless of age, who are 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 your Medical Plan to continue coverage past age 26

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, **www.healthcare.gov** will guide you through the process.

☑ HIPAA Special Enrollment Rights Notice

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

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact Mach Natural Resources HR at 405-252-8100.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

What is "balance billing" (sometimes called "surprise billing")?

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

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

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

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not

to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

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

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

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

When balance billing isn't allowed, you also have the following protections:

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

If you believe you've been wrongly billed, you may contact the Federal No Surprises Helpdesk at 1-800- 985-3059.

Visit **https://www.cms.gov/nosurprises** for more information about your rights under federal law.

Patient Protection Notice

The Mach Natural Resources medical plans generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from BCBS or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, Mach Natural Resources HR at 405-252-8100 or HR@machnr.com

MACH NATURAL RESOURCES' NOTICE OF PRIVACY PRACTICES

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

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by the Mach Natural Resources Medical Plans (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on 1/1/2027.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Mach Natural Resources requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or Required by Law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to Your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of Mach Natural Resources for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting

of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Mach Natural Resources

14201 Wireless Way Ste. 300

Oklahoma City, OK 73134

405-252-8124 & HR@machnr.com

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit **www.hhs.gov/ocr** for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.