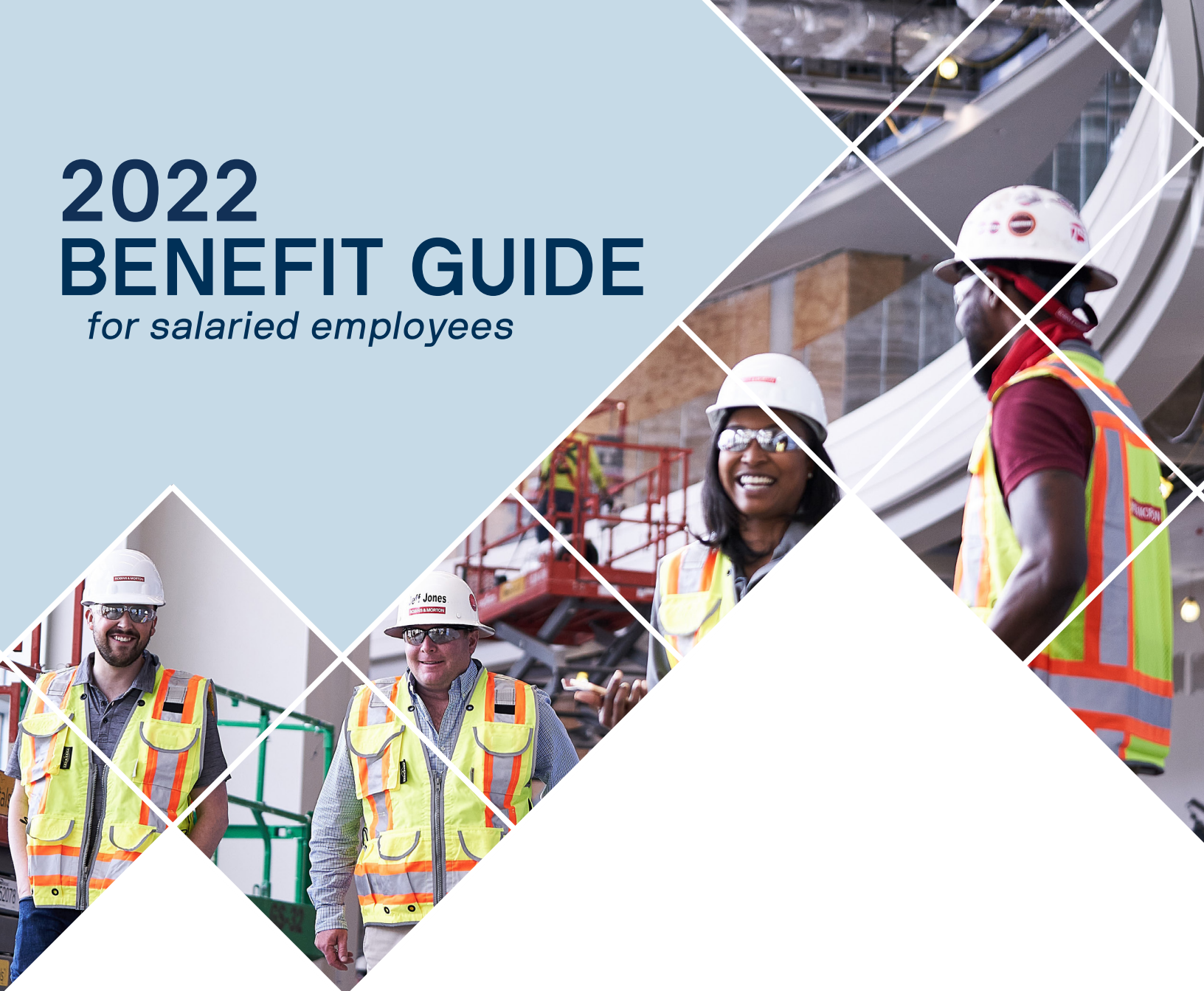


2022 BENEFIT GUIDE

for salaried employees



ROBINS & MORTON

THINGS TO KNOW FOR 2022

- **New Benefits:** Robins & Morton has added three new benefits for your wellbeing--a Care.com subscription, Virta, and SimpleHSA.
- **HSA Contributions:** The IRS sets the amounts you can contribute to an HSA for 2022. If your coverage is employee only, you may contribute up to \$3,650 and families may contribute \$7,300 in 2022. This total includes the annual Robins & Morton contribution. There is an additional \$1,000 catch-up amount allowed for employees 55 years and older. Manage your weekly contributions online through Fidelity at www.401k.com.
- **R&M HSA deposits:** Robins & Morton will match your weekly contribution dollar for dollar until the R&M deposit limit has been reached based on your coverage tier in the medical plan.
- **401k Contributions:** The 2022 annual limit is \$20,000, with a \$6,500 catch up for those age 50 and over.
- **Blue Cross Blue Shield updated their contract cards.** All employees enrolled in the medical plan will receive a new card.
- **The annual dental plan maximum has increased to \$2500 per enrolled person.**

WHAT HAPPENS IF I DON'T ENROLL?

EXISTING EMPLOYEES

If you do not enroll during this time, you will be re-enrolled in the same plan you had in 2021. You must go through Open Enrollment and enroll in the Limited Purpose Flexible Spending Account and Dependent Care Account or you will not have a deduction in 2022. This does not carryover from year to year. Your next opportunity to enroll will be in the fall of 2022 during the Open Enrollment period for the 2023 plan year.

NEW HIRES

If you choose not to enroll, you will not be covered for 2022. You may enroll in benefits upon hire date. This is your eligibility date. You have 30 days from the eligibility date to enroll in benefits.

EMPLOYEES WITH LIFE EVENTS

If you have a qualifying life event (marriage, divorce, birth of a child, etc.), you are eligible to enroll in benefits within 30 days of the event date. Please contact HR if you have a life event during the year.

BUILDING FORWARD® & BENEFITS

Collaboration and innovation apply to your benefit programs, just as it does to the job. The improved 401k has lower cost investments and allows immediate participation at your hire date. Fidelity has reduced the minimum to invest your HSA to \$1 on some investments so you can build your fund sooner. While some changes are small wins, let's celebrate these in our Building Forward culture. The wins are not only the benefits themselves, but also how the benefits provide good value to you that are easy to use at an affordable cost.



(205) 803-0102

The HR Helpline is available to answer your questions from 8am to 4pm CST Monday–Thursday and 8am to 2pm CST on Friday, with messages checked daily.

Benefits Guide

FOR SALARY EMPLOYEES

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2022 CHECKLIST FOR OPEN ENROLLMENT

TO BEGIN:

Log in to hr.robinsmorton.net. Select "Open Enrollment." Use the arrows at top right to move between benefit sections. All dependents MUST have a social security number to be enrolled in any plan.

☐ **COMPANY PAID LIFE & AD&D.....PAGE 20**

Is your beneficiary information up-to-date?

- Information needed: full name, social security number, birthdate, address

☐ **SAVER.....PAGE 7**

Waive or Select

- Who is covered? Use the drop down menu for coverage and select dependents at the bottom, if applicable.

☐ **CATASTROPHIC.....PAGE 8**

Waive or Select

- Who is covered? Use the drop down menu for coverage and select dependents at the bottom, if applicable.

☐ **HSA.....PAGE 9**

Enroll in the HSA program

- Set contributions at 401k.com

☐ **SPENDING ACCOUNTS.....PAGE 22**

Dependent Care Account (DCA).....page 22

- Elect this account if you would like to contribute to a tax deferred account to pay for childcare expenses.

Limited Purpose Flexible Spending Account.....page 22

- Elect this account if you would like to contribute to a tax deferred account to pay for vision and dental needs only.

☐ **DENTAL.....PAGE 14**

Waive or Select

- Who is covered? Use the drop down menu for coverage and select dependents at the bottom, if applicable.

☐ **VISION.....PAGE 16**

Waive or Select

- Who is covered? Use the drop down menu for coverage and select dependents at the bottom, if applicable.

☐ **EMPLOYEE OPTIONAL LIFE.....PAGE 20**

Waive or Select

- Coverage amount: if this is your first time electing this benefit, you can only elect \$25,000 in coverage. You can step up to the next coverage level if you had this benefit in 2021.
- Elect beneficiaries: percentages must add up to 100%. Contingent beneficiaries are optional.

☐ **SPOUSE OPTIONAL LIFE.....PAGE 20**

Waive or Select

- Coverage amount: if this is your first time electing this benefit, you can only elect \$10,000 in coverage. You can step up to the next coverage level if you had this benefit in 2021. Contingent beneficiaries are optional.
- Elect beneficiaries: percentages must add up to 100%. Contingent beneficiaries are optional.

☐ **CHILD OPTIONAL LIFE.....PAGE 20**

Waive or Select

- Coverage amount: \$10,000

- Elect beneficiaries: percentages must add up to 100%. Contingent beneficiaries are optional.

☐ **LONG TERM DISABILITY.....PAGE 17**

Waive or Select LTD - EE Paid or LTD - ER Paid

- LTD - EE Paid: employee pays the premium. When the benefit is received, it is not taxable.
- LTD - ER Paid: Robins & Morton pays the premium. When the benefit is received, it is taxable.

☐ **ACCIDENT.....PAGE 18**

Waive or Select - High plan or Low plan

- High plan: higher weekly premiums, higher payout if used.
- Low plan: lower weekly premiums, lower payout if used.
- Who is covered? Use the drop down menu for coverage and select dependents at the bottom, if applicable.

☐ **INDEMNITY.....PAGE 19**

Waive or Select - High plan or Low plan

- High plan: higher weekly premiums, higher payout if used.
- Low plan: lower weekly premiums, lower payout if used.
- Who is covered? Use the drop down menu for coverage and select dependents at the bottom, if applicable.

☐ **BENEFITS SUMMARY**

Print this page for your records

TO FINISH:

Select I'm Finished. Enter your Username, Password, and Social Security Number. You are required to enter the dashes in the social security number field during submission. Your enrollment will not be submitted for approval if these are missing. Press "DONE" to submit your benefits for approval.

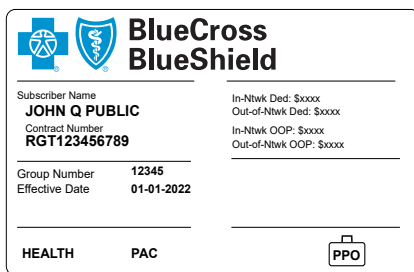


Benefit Cards & Access

Knowing the benefit cards in your wallet and benefit apps on your phone will simplify your life. You have two kinds of benefit cards with the Robins & Morton plan; cards that identify you as a plan participant and debit cards to provide convenient payment options.

You will not receive a new card unless you request one from the vendor or the HR Helpline at 205.803.0102. You can also download the app and cards to your mobile device.

IDENTIFICATION CARDS



ALABAMA BLUE



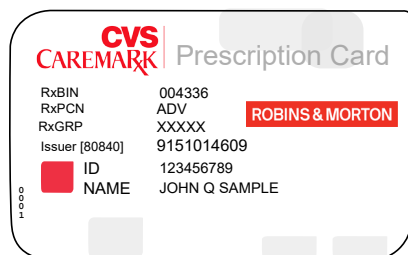
Blue Cross Blue Shield of Alabama administers the medical benefits for Robins & Morton. Present this card when you visit your doctor, hospitals, laboratories and others that provide you medical services. You can also access the mobile app for your card. Most providers will ask for your ID card with each visit so keep this card with you for all visits and emergencies.

Customer Service:

Website:

800.292.2262

<http://www.bcbsal.org>



CVS CAREMARK



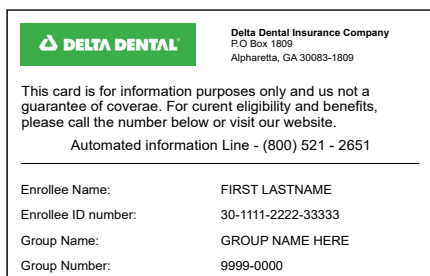
Your prescription drug benefits are provided by CVS/Caremark. Present this card at your pharmacy to fill your prescriptions. In most cases, you will only need to present this card once to a pharmacy. You will receive this card upon enrollment in a medical plan.

Customer Service:

Website:

800.334.8134

<http://www.cvs.com>



DELTA DENTAL



We use the Delta Dental PPO and Delta Premier networks for our dental plan. You will need to show this card at the dentist.

You can obtain additional cards on the Delta Dental website or by downloading the Delta Dental Mobile App available on both iTunes and the Android App Store.

Customer Service:

Website:

800.521.2651

<http://www.deltadentalins.com>



VSP VISION CARE



VSP is paperless and does not issue identification cards. VSP provides our voluntary vision care program to Robins & Morton. At your next visit tell your vision provider your coverage is VSP. The office will locate you in the VSP system. You can obtain a card that does not show your name on the VSP website or by downloading the VSP Mobile site at <https://www.vsp.com>.

Customer Service:

Website:

800.877.7195

<https://www.vsp.com>

DEBIT CARDS



PAYFLEX MOBILE



Debit cards from PayFlex provide Robins & Morton employees with point-of-purchase access to their Limited Purpose Flexible Spending Account. Remember, you fund the LPFSA with contributions from your paycheck to pay for vision or dental expenses only.

This is a MasterCard debit card and you will receive periodic replacements about 30 days before the date shown on the front of the card. If your card is lost or stolen, please contact PayFlex immediately to prevent unauthorized use of your card.

Customer Service:

844.729.3539

Website:

<http://mypayflex.com>

Lost or stolen card:

844.729.3539



NETBENEFITS



For those that enrolled in the Saver or Catastrophic Health Plan, you have access to a Health Savings Account at Fidelity Investments. You must go to the Fidelity website and open your HSA before any contributions can be deposited to your account. Robins & Morton will make regular deposits to the HSA along with any contributions you make, up to the IRS limits. You may use this card to access your HSA funds to pay for medical expenses.

REMEMBER: You must open your account on the Fidelity website. Open your account by going to the website, log in just like you would to access your 401(k) and click the word OPEN next to the Health Savings Account and answer several questions.

This is a Visa debit card and you will receive periodic replacements. If your card is lost or stolen, please contact Fidelity immediately to prevent unauthorized use of your card.

HSA Customer Service:

800.544.3716

Website:

<http://www.401k.com>

Lost or stolen card:

888.377.0323



Saver Plan

This plan is designed to give you the maximum flexibility when it comes to your healthcare. Using a tax advantaged savings opportunity, the Health Savings Account, you can save and invest for future healthcare expenses, even into retirement.



PLAN DESIGN: The Saver Plan has a \$2,800 individual and a \$5,000 aggregate deductible for families. The plan also limits out of pocket costs after meeting the deductible. The plan focuses on a low premium in return for reasonable point of service costs and provides a large incentive to act as consumers of healthcare using your Health Savings Account.

PREVENTIVE CARE: The Plan pays 100% of the cost of preventive care for each covered member of your family. This ensures that you can get the regular check-ups and tests recommended for your age and gender. In addition, diagnostic tests are covered under the preventive care benefit, including colonoscopies, mammograms, and cervical exams (if you meet age or health requirements).

PRESCRIPTION DRUGS: Once you have met the annual deductible, you pay a copay for prescription drugs as long as you use a network pharmacy. Prescription drugs are subject to the deductible, except generic preventive drugs. Generic preventive drug copays are now \$0. Medical and Pharmacy claims accumulate toward the total out of pocket max of \$4,000 individual and \$8,000 family.

OTHER COVERED EXPENSES: All other expenses are subject to a deductible. After you meet the deductible, the Plan will pay 80% of the cost. An HSA can help you pay deductibles and coinsurance. Once the HSA is exhausted, you will pay your share of the cost of your medical care until you have met the out of pocket maximum. At that point, the Plan pays 100% of the cost of your covered expenses.

HSA: Robins & Morton will match your weekly contribution dollar for dollar until the R&M deposit limit has been reached based on your coverage tier in the medical plan. Please see page 9 for more details. You can also deposit money into your HSA on a pre-tax basis. The HSA will help you pay for out-of-pocket expenses. The money in your HSA can be used to pay the deductible, coinsurance, and prescription drugs for any eligible medical expense, or you can save your HSA to use in retirement.

OUT-OF-POCKET COSTS FOR SAVER PLAN

DEDUCTIBLE		MEDICAL OUT-OF-POCKET MAX	
Individual	Family	Individual	Family
\$2,800	\$5,000	\$4,000	\$8,000

COST OF SAVER PLAN

	EMPLOYEE ONLY	EMPLOYEE+SPOUSE	EMPLOYEE+CHILDREN	FAMILY
Total Cost:	\$687	\$1,472	\$1,089	\$1,603
R&M Pays:	\$623	\$1,331	\$986	\$1,449
Monthly:	\$64	\$141	\$103	\$154
Weekly:	\$14.77	\$32.54	\$23.77	\$35.54

Catastrophic Plan

This plan allows you to accept more risk with your healthcare for no premium but a much higher deductible. Now you have a direct comparison to plans available on the Exchange, allowing you to see the value of the Robins & Morton program.



PLAN DESIGN: The Catastrophic Plan has a \$5,000 deductible for individuals, and a \$10,000 deductible for families. This plan also limits your out-of-pocket costs after meeting the deductible. It focuses on a low level of coverage with no contributions, leaving the risk for most healthcare expenses with you. You can save for those risks in your Health Savings Account (HSA). Unlike plans you might find on the Exchange, the plan shares the same wide network of doctors, hospitals and other providers as the other Robins & Morton plans.

PREVENTIVE CARE: The Plan pays 100% of the cost of preventive care for each covered member of your family. This ensures that you can get the regular check-ups and tests recommended for your age and gender. In addition, diagnostic tests are covered under the preventive care benefit, including colonoscopies, mammograms and cervical exams (if you meet age or health requirements).

PRESCRIPTION DRUGS: Once you have met the annual deductible, you pay a copay for prescription drugs as long as you use a network pharmacy. Prescription drugs are subject to the deductible, except generic preventive drugs. Generic preventive drug copays are now \$0.

OTHER COVERED EXPENSES: All other expenses are subject to a deductible. After you meet the deductible, the plan will pay 70% of the cost. An HSA can be used to pay the deductibles and coinsurance. Once the HSA is exhausted, you will pay your share of the cost of medical care until you have met the out of pocket maximum. At that point, the plan pays 100% of your covered expenses.

HSA: Robins & Morton will match your weekly contribution dollar for dollar until the R&M deposit limit has been reached based on your coverage tier in the medical plan. Please see page 9 for more details. You can also deposit money into your HSA on a pre-tax basis. The HSA will help you pay for out-of-pocket expenses. The money in your HSA can be used to pay the deductible, coinsurance and prescription drugs for any eligible medical expense, or you can save your HSA to use in retirement.

OUT-OF-POCKET COSTS FOR CATASTROPHIC PLAN

DEDUCTIBLE		MEDICAL OUT-OF-POCKET MAX	
Individual	Family	Individual	Family
\$5,000	\$10,000	\$6,550	\$13,100

COST OF CATASTROPHIC PLAN

	EMPLOYEE ONLY	EMPLOYEE+SPOUSE	EMPLOYEE+CHILDREN	FAMILY
Total Cost:	\$623	\$1,331	\$986	\$1,449
R&M Pays:	\$623	\$1,331	\$986	\$1,449
Monthly:	\$0	\$0	\$0	\$0
Weekly:	\$0	\$0	\$0	\$0



Health Savings Account

A Health Savings Account (HSA) allows you to set aside money to pay for out of pocket healthcare expenses. The HSA is your money that you control and invest, and you don't pay taxes on the HSA money you contribute.



LEARN ABOUT THE HSA MATCH

Robins & Morton will match your weekly contribution dollar for dollar until your annual company contribution has been reached. The company contribution is based on your enrollment in the medical plan. See chart below for details.

For example, if you are enrolled as employee only in the medical plan and contribute \$100 per week to your HSA, Robins & Morton will contribute \$100 per week until the \$500 limit has been reached.

Eligible expenses include medical copays, medical coinsurance, deductibles, and prescription copays. Vision and dental charges are also reimbursable by the HSA. If you don't use all of the money in your HSA during the year, those dollars are yours to keep and invest. While the IRS limits the amount you can contribute each year, there is no limit on the balance for your HSA. You can pay medical bills from your HSA with a debit card that will be mailed to your address on file with Robins & Morton, after your account has been opened.

HOW TO OPEN AN HSA

After your enrollment has been processed, go to www.401k.com and open your account. You can also call 1-800-544-3716 to set up your account.

HOW MUCH CAN I PUT IN MY HSA?

The annual contribution limit for your HSA depends on who you enroll in the health plan, the age of the employee and the amount contributed by Robins & Morton. Robins & Morton will match your weekly contributions, up to your contribution limit.

Use the calculator below to determine your contribution limit and the weekly amount you can contribute from your check.

EXAMPLE: Kris is enrolled in employee plus spouse coverage and will turn 55 on June 21, 2022. The maximum the IRS will allow to contribute to the HSA is \$7,300, plus another \$1,000 for being over age 55. Robins & Morton will contribute \$750 of that total leaving a total of \$7,550, or \$145.19 per week that Kris could contribute during the full year to the HSA.

MANAGE YOUR HSA

Weekly contributions are now managed and processed at www.401k.com. You can change your contribution amount as many times throughout the year, according to your own personal circumstances. Your HSA dollars can also be invested like your 401K, producing tax-saving gains on your investments.

HSA CONTRIBUTION LIMITS FOR 2022

	SINGLE	FAMILY
TOTAL Limit	\$3,650	\$7,300
OVER 55 CATCH UP	\$1,000	\$1,000

ROBINS & MORTON CONTRIBUTION

YOUR ENROLLMENT	ANNUAL SEED MONEY
EMPLOYEE ONLY	\$500
EMPLOYEE+SPOUSE	\$750
EMPLOYEE+CHILDREN	\$750
FAMILY	\$1,000

COMPUTE
YOUR
WEEKLY
CONTRIBUTION

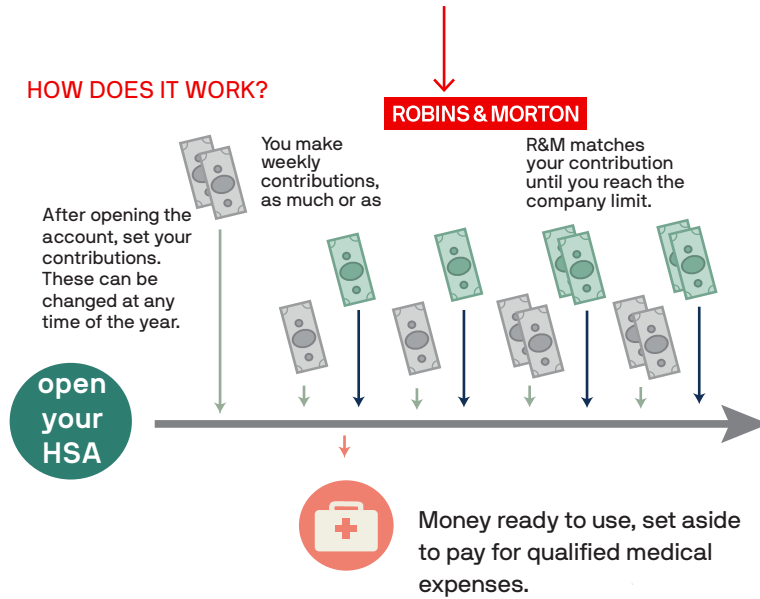


YOUR FAMILY	EXAMPLE	YOU
What is your TOTAL Limit?	\$7,300	
Enter \$1,000 if you will be 55 or older on December 31, 2021	\$1,000	
SUBTOTAL	\$8,300	
Subtract your annual seed money	(\$750)	
MAXIMUM ANNUAL CONTRIBUTION	\$7,550	
Divide by 52 to find the maximum WEEKLY contribution	\$145.19	

How to use the HSA

A Health Savings Account (HSA) allows you to set aside money to pay for out of pocket healthcare expenses. The HSA is your money that you control and invest, and you don't pay taxes on the HSA money you contribute. It can also be a tool used for long term investing, savings and retirement planning.

HOW DOES IT WORK?



ROBINS & MORTON CONTRIBUTION

YOUR ENROLLMENT	ANNUAL SEED MONEY
EMPLOYEE ONLY	\$500
EMPLOYEE+SPOUSE	\$750
EMPLOYEE+CHILDREN	\$750
FAMILY	\$1,000

Any money you don't use by the end of the year is yours to keep! Fidelity makes it easier to invest the money for medical expenses.

HOW DO YOU INVEST IT?

Fidelity has a feature called a "trigger amount." This allows you to keep some money in your account for medical expenses. Anything you contribute over the trigger amount will automatically flow into the investment side. This feature helps ensure that you and your family are financially prepared for a medical need, while also allowing you to be in control of your money and investments.

For example, Kris decides to keep \$500 in the savings portion of his HSA. Anything he contributes over \$500 will pour into the investment portion of his HSA. After a doctor's visit, he pays his medical bill using his HSA savings. Now his contributions will go toward his savings account until he reaches his trigger amount (\$500).

TRIPLE TAX ADVANTAGE

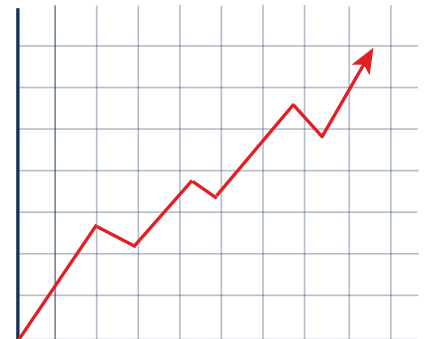
An HSA is often called a "triple tax advantage" account. These advantages are:

- You make contributions before tax deductions
- You don't pay taxes when you pay for a medical expense
- You don't pay taxes on your investment and interest earnings

SimpleHSA

Now it's easier than ever to save money for medical expenses.

This programs allows your HSA to begin without the need to manually open the account. As soon as you enroll in the HSA, your account is ready for you to make contributions.





Prescription Plan



The prescription drug plan is administered through CVS Health. You will be automatically enrolled for prescription drug coverage in CVS Health when you enroll in the Robins & Morton health plan.

We encourage you to discuss with your doctor and pharmacist the availability of generic preventive drugs for your maintenance conditions. This plan encourages the use of generic and preferred brand drugs. You can find a list of the preventive generics for \$0 on my.robinsmorton.com.

Robins & Morton has implemented generic step therapy that promotes the use of generic medications first. If you choose to use certain brand-name drugs before trying a generic medication, your prescription may not be covered and you will pay the full cost. Please go to the Resources tab on my.robinsmorton.com for a full list of brand name drugs that require a generic first.

GOOD TO KNOW

Copays for preventive generics are not subject to the deductible. You must meet the full deductible before the copays will apply to other prescription drugs under these plans. You can find drugs available at my.robinsmorton.com/salary/coverage/medical

PRESCRIPTION PLAN

	GENERIC PREVENTIVE	GENERIC OTHER	PREFERRED	NON-PREFERRED	SPECIALTY
1-34 Days Supply	\$0	\$10	\$30	\$70	\$150
90 Day Supply	\$0	\$25	\$75	\$175	

CVS HEALTH ALSO PROVIDES THESE PREVENTIVE VACCINATIONS AT THEIR STORES AT NO COST TO YOU:

CHILDREN UP TO AGE 18			CHILDREN & ADULTS		ADULTS
Haemophilus B	Diphtheria, Tetanus	Rotavirus	Hepatitis B	Pneumonia	Hepatitis A & B
Measles, Mumps, Rubella, Varicella	Haemophilus B, Hepatitis B	Meningococcal, Haemophilus B, Tetanus	Measles, Mumps, Rubella	Human Papilloma-virus	Tetanus, Diphtheria Toxoids
Diphtheria, Tetanus, Pertussis, Haemophilus B	Diphtheria, Tetanus, Pertussis, Inactivated Poliovirus	Diphtheria, Tetanus, Pertussis	Meningococcal	Hepatitis A	Zoster (Zostavax)
Diphtheria, Tetanus, Pertussis, Inactivated Poliovirus, Haemophilus B	Diphtheria, Tetanus, Pertussis, Inactivated Poliovirus, Hepatitis B	Inactivated Poliovirus	Varicella, COVID-19	Influenza	



Telemedicine

Amwell offers an affordable, easy, and convenient way to consult with a doctor by phone, web or a mobile device. You have your choice of U.S. board-certified doctors with no appointment and no waiting. With 24/7/365 access via the web or your mobile device, you can have a consultation, diagnoses and prescriptions.



SEE A DOCTOR ONLINE, ANY TIME, ANYWHERE.

You can't predict getting sick, but you can be prepared. Amwell makes seeing a doctor 24/7 as simple as picking up a smartphone or tablet. The service is affordable, convenient, and secure.

- Cough / Sore Throat
- Fever
- Headache
- Pinkeye
- Sinus Infection
- Flu
- Bronchitis
- Allergies
- Ear Infection

Three easy ways to connect to a doctor fast:

MOBILE



Video visit via the Amwell mobile app

WEB



Visit www.amwell.com

PHONE



Dial 1-844-SEE-DOCS
(1-844-733-3627)

Make sure to enter Service Key **ROBINSMORTON** at enrollment.
Sign up now, so your account is ready when you need it.



Virta

With Virta, naturally reverse Type 2 Diabetes at no cost to you.



New for 2022, Robins & Morton is happy to introduce Virta as a new benefit for our teams. Virta specializes in reversing Type 2 diabetes by natural causes -- without the need for excessive exercise, constant medication and extreme dieting. With a sustainable method, healthy weight loss is just one of the benefits of Virta.

Robins & Morton will fully cover the cost of Virta for all employees, spouses, and adult dependents with type 2 diabetes and prediabetes who are enrolled in a BCBS AL medical plan.

WHAT IS VIRTA?

Virta is a medically supervised, research-backed treatment that reverses type 2 diabetes, meaning that patients can lower their blood sugar and A1c, all while reducing diabetes medications and losing weight.

HOW DOES IT WORK?

Virta uses nutritional ketosis to naturally lower blood sugar and turn the body into a fat-burning machine. There is NO surgery, required exercise, or calorie counting on Virta.

With Virta's personalized treatment plan, each patient gets medical supervision from a physician-led care team, a one-on-one health coach, diabetes testing supplies, educational tools like videos and recipes, and a private online support community.

Virta provides around-the-clock monitoring and care—there are no waiting rooms and no lines. With an easy-to-use mobile and desktop app, Virta can be done from anywhere.

GETTING STARTED

To get started with Virta, go to www.virtahealth.com/join or email support@virtahealth.com.



**Your blood sugar
on carbs**

**Your blood sugar
on Virta**



Dental

The Delta Dental PPO plan makes it easy for you to find a dentist and easy to control your costs when you visit a network dentist.



Delta's PPO network dentists accept reduced fees for covered services they provide you, so you'll usually pay the least when you visit a PPO network dentist. This also ensures Delta Dental PPO dentists won't balance bill you the difference between the contracted amount and their usual fee.

You can access your benefits and eligibility, order ID cards, find a dentist near you and get information about your claims with Delta Dental's online services. Check www.deltadentalins.com, Delta Dental's oral health resources for tips and information that can help keep your smile healthy.

DELTA DENTAL

	EMPLOYEE ONLY	EMPLOYEE+SPOUSE	EMPLOYEE+CHILDREN	FAMILY
Total Cost:	\$32	\$74	\$71	\$96
R&M Pays:	\$22	\$50	\$48	\$65
Monthly:	\$10	\$24	\$23	\$31
Weekly:	\$2.31	\$5.54	\$5.31	\$7.15

DELTA DENTAL BENEFITS Primary enrollee, spouse, and children up to age 26

Deductibles	\$50 per person/ \$150 per family each calendar year
Deductibles waived for Diagnostic & Preventive	Yes
Maximums	\$2,500 per person each calendar year
Diagnostic & Preventive counts toward maximum	Yes

BENEFITS AND COVERED SERVICES Percent of Allowed Amount

Diagnostic & Preventive Services: exams, cleanings, x-rays, sealants	100%
Basic Services: fillings, simple tooth extractions	100%
Endodontics (root canals) covered under basic services	100%
Periodontics (gum treatment) covered under major services	50%
Oral surgery covered under basic services	100%
Major Services: crowns, inlays, onlays and cast restorations, bridges and dentures	50%
Orthodontic Benefits for dependent children	50%
Orthodontic Maximum, Lifetime (per child)	\$1,500 Lifetime up to age 19
Prosthodontics: bridges and dentures	50%

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, PPO contracted fees for Premier dentists and PPO contracted fees for non-Delta Dental dentists.

STAY CONNECTED WITH DELTA DENTAL

At deltadentalins.com, all the information you need is at your fingertips. You can check your plan details, find an in-network dentist and more.

Create an account

1. Go to deltadentalins.com.
2. Click on Register Today in the Online Services section.

With an online account, you can:

- Check your plan details and eligibility
- Review claim statements and plan documents
- View or print your ID card

Find a dentist

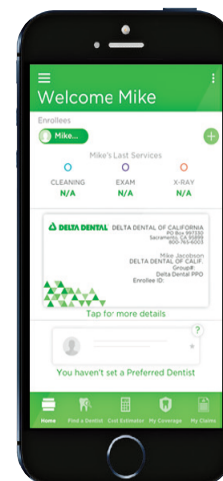
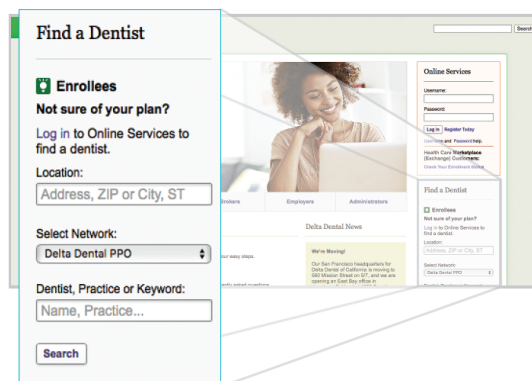
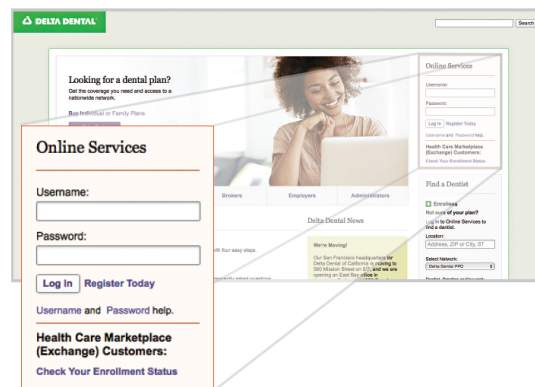
1. Go to deltadentalins.com.
2. In the Find a Dentist section, enter your address and select your network from the drop-down menu.
3. Click Search.

Browse Yelp reviews, check office hours and see the address on a map.

Download the app

1. Open the App Store or Google Play.
2. Search for "Delta Dental."
3. Download the free app titled Delta Dental by Delta Dental Plans Association.

Review your plan details, pull up your ID card and try out the musical toothbrush timer.



Delta Dental en Español es.deltadentalins.com



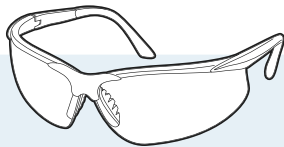
Your eyes deserve the best care to keep them healthy year after year.



PERSONALIZED CARE

You'll get quality care that focuses on your eyes and overall wellness through a WellVision Exam® from a VSP doctor. When you see a VSP doctor, you'll get the most out of your benefit and have lower out-of-pocket costs. Plus, with a VSP doctor your satisfaction is guaranteed—if you're not 100% happy, they will make it right.

SAFETY GLASSES—ADDED BENEFIT!



Robins & Morton is now offering ProTec Safety Glasses under our vision plan. With the ProTec Safety Plan, you get an affordable benefit that includes a fully covered safety frame from the ProTec Eyewear collection, that meets current impact protection standards for maximum safety in addition to your regular prescription lenses. Visit www.vsp.com to find a list of ProTec providers in your area.

HEARING AID DISCOUNT

The TruHearing MemberPlus Program includes:

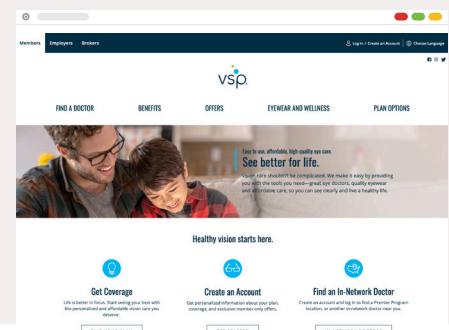
- Savings of up to 50% on hearing aids
- Yearly comprehensive hearing exams for \$75
- 3 visits with a hearing professional after purchase (fitting, programming and/or adjustments)
- Manufacturer's coverage for a one-time loss or damage for three years (replacement fee paid to manufacturer)
- 3-year repair warranty
- 48 batteries per purchased hearing aid
- VSP members may also add up to four guest members (parents, grandparents, siblings) for a VSP-exclusive rate of \$71 each. Best of all, if a member already has a hearing aid benefit from their health plan or employer, they can combine it with this program to maximize the benefit and reduce their out-of-pocket expense.

VSP VISION PLAN

YOU PAY	EMPLOYEE ONLY	EMPLOYEE+SPOUSE	EMPLOYEE+CHILDREN	FAMILY
Total Cost:	\$8.98	\$15.43	\$15.72	\$24.73
Monthly:	\$8.98	\$15.43	\$15.72	\$24.73
Weekly:	\$2.07	\$3.56	\$3.63	\$5.71

VIEW YOUR VISION BENEFITS

To view your vision benefits or to find a doctor, visit www.vsp.com.





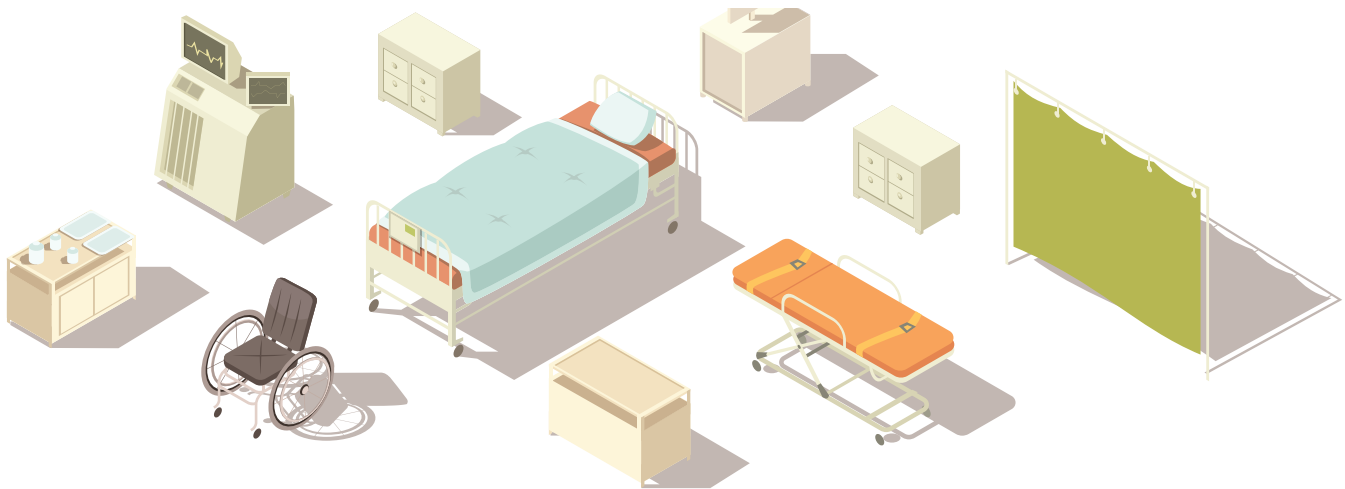
Short Term Disability

The Robins & Morton Short Term Disability Plan provides financial protection for you by paying your salary should you become disabled. A serious illness or injury can harm more than your health. It can have a greater impact than you may be financially prepared for.

ROBINS & MORTON

The amount you receive is based on your base salary you earned when your disability began. This benefit is self-administered and fully paid by Robins & Morton. Short Term Disability Insurance pays 100% of your base salary for days 6–90 of your disability.

For eligibility, benefit restrictions and summary on this benefit, please refer to the guidelines posted on my.robinsmorton.com. This benefit pays a maximum of 90 days in a rolling 12 month period.



Long Term Disability

Long Term Disability Insurance provides long term financial security in the event you are unable to work longer than 90 days due to an illness, injury, or accident.



Robins & Morton offers LTD coverage at no cost to employees to help prevent this financial burden if you become disabled. If you suffer a covered disability while insured by this plan, you will receive monetary benefits designed to help you maintain your normal lifestyle. This program covers disabling injuries or sicknesses that last beyond the 90 day elimination period. This plan pays a benefit up to 60% of your monthly covered earnings—to a maximum of \$15,000 per month. Robins & Morton is happy to pay 100% of the premiums for this benefit.

If Robins & Morton pays the premiums, any benefits you receive from the plan are taxable. Due to this, some employees elect to pay the premium themselves. If you elect to pay for LTD yourself, the cost of the insurance program is \$0.424 per \$100 of monthly earnings, and any benefit received would not be taxable.



Accident Insurance

Accidents can happen when you least expect them.

MetLife

You can't plan for accidents, but you can financially prepare for them when they happen. In 2018, there were more than 45,000,000 trips to the emergency room in the U.S. due to accidents. With an average cost of \$1,318 per visit to the ER, accident coverage make life's unpredictable moments more financially manageable.

Group Accident Insurance can help you be better prepared by providing you with a payment to use as you see fit if you experience a covered event. There are no waiting periods for coverage to begin and payment will be in addition to any other insurance you may have. This payment can help you focus more on getting back on track and less on the extra expenses an accident may bring.

See page 32 for types of benefits associated with this plan.

THINK ABOUT THE LIKELIHOOD OF HAVING AN ACCIDENT:

- Your child gets hurt playing sports or on the school playground
- You injure yourself while doing home repairs or while on vacation
- Your spouse slips and falls on the stairs or on a slippery floor

RATES – LOW PLAN

YOU PAY	EMPLOYEE ONLY	EMPLOYEE+SPOUSE	EMPLOYEE+CHILDREN	FAMILY
Monthly:	\$9.03	\$17.80	\$20.63	\$25.23
Weekly:	\$2.08	\$4.11	\$4.76	\$5.82

RATES – HIGH PLAN

YOU PAY	EMPLOYEE ONLY	EMPLOYEE+SPOUSE	EMPLOYEE+CHILDREN	FAMILY
Monthly:	\$12.74	\$24.97	\$28.83	\$35.28
Weekly:	\$2.94	\$5.76	\$6.65	\$8.14



Indemnity Insurance

Indemnity Insurance provides cash to help pay for a hospitalization.

MetLife

Hospital indemnity insurance provides you with payments when you are admitted and when you are confined to a hospital due to an accident (not work related) or illness. Your benefit is a flat amount paid for admission and a daily amount is paid for each day of a hospital stay. It also pays extra benefits for intensive care.

Payments are made directly to you to use as you see fit. They can be used to help pay for medical plan deductibles and copays, for out-of-network stays, for your family's everyday living expenses, or for whatever else you need while recuperating from an illness or accident.

While this is not medical insurance, it can help you pay bills from the first day you are in the hospital.

You are eligible to enroll yourself and your eligible family members in this plan. This coverage is portable, so you can take it with you if your employment status changes. Your coverage will only end if you stop paying your premium or if your current employer chooses to terminate the Group Hospital Indemnity insurance policy.

See page 32 for types of benefits associated with this plan.

RATES – LOW PLAN

YOU PAY	EMPLOYEE ONLY	EMPLOYEE+SPOUSE	EMPLOYEE+CHILDREN	FAMILY
Monthly:	\$19.57	\$32.33	\$32.33	\$47.00
Weekly:	\$4.52	\$7.46	\$7.46	\$10.85

RATES – HIGH PLAN

YOU PAY	EMPLOYEE ONLY	EMPLOYEE+SPOUSE	EMPLOYEE+CHILDREN	FAMILY
Monthly:	\$39.13	\$63.46	\$63.46	\$92.34
Weekly:	\$9.03	\$14.64	\$14.64	\$21.31



Basic Life & AD&D Insurance

Robins & Morton provides a basic life insurance benefit based on your salary.



Accidental death & dismemberment coverage is also included that can pay up to double the basic life insurance coverages. Robins & Morton pays the entire cost of the plan.

BASIC LIFE & AD&D INSURANCE

SALARY	BASIC LIFE	AD&D
Up to \$25,000	\$25,000	\$25,000
\$25,000.01–\$50,000	\$50,000	\$50,000
\$50,000.01–\$75,000	\$75,000	\$75,000
\$75,000.01–\$100,000	\$100,000	\$100,000
Over \$100,000	\$250,000	\$250,000



Optional Life & AD&D

You can elect life insurance coverage at several levels. The maximum optional life for any employee is \$250,000. With optional life you will receive an equal amount of Accidental Death & Dismemberment coverage to help pay expenses if you or your spouse are seriously injured or killed in a covered accident. You may also elect \$10,000, \$25,000 or \$50,000 of optional life insurance for your spouse. Optional life insurance for your unmarried, dependent children is also available with one policy covering all eligible children. If you apply for more than \$200,000, you will be required to provide evidence of insurability. This form is available by contacting the HR Helpline at (205) 803-0102. You will not be covered for the optional life over the guaranteed amount until this form is submitted and approved. The cost of both employee and spousal coverage are based on your age as of January 1 of the current year.

Note: When choosing a spouse or other dependent as a beneficiary, make sure to assign "Both" as the Type during your online enrollment.

New enrollments must start out at \$25,000 coverage level.

First Name *

Middle Initial

Last Name *

Type * ▼

GOOD TO KNOW

Please review your beneficiary designation as you enroll. Unless you have named the correct beneficiaries, benefits may be paid to someone you did not choose or payment may be delayed. Remember, the employee is always the beneficiary for any life insurance on your dependents.

\$ The Robins & Morton Retirement Savings Plan

You can simplify saving for retirement with the Robins & Morton Retirement Savings Plan. The plan offers you the ease of payroll deduction, tax advantages and the experience of Fidelity Investments to make saving easy.



With a number of different funds to choose from, you can position yourself for the retirement of your dreams.

You may contribute up to 90% of your wages to the plan each pay period and invest your money in a wide range of investment alternatives to fit your personal risk tolerance. The IRS does have a dollar limit on your contributions and allows participants over age 50 to contribute an additional catch-up amount. To fit your particular tax situation, you may choose to invest your dollars on a pre-tax basis or on an after tax basis in the ROTH option. The plan also has a profit sharing feature for employees after they complete one year of service. The profit share is a discretionary contribution from Robins & Morton to encourage everyone to save for retirement. The profit sharing contribution becomes fully vested after six years.

All employees over age 18 become eligible to contribute at hire date. You will be automatically enrolled in the plan after 30 days of employment with a starting contribution of 4% of your salary unless you change your contribution percentage on the Fidelity website, www.401k.com, or by calling Fidelity at 800.835.5097 before you reach 30 days of service.

To help you with your choices of investments, CAPTRUST Financial Advisors are available to you at no cost. They can help you design your retirement portfolio specific to your financial goals and discuss your personal retirement savings situation.

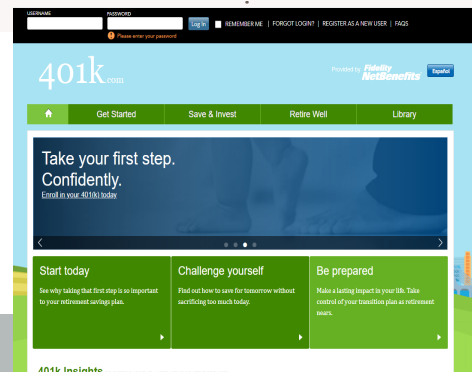
You can find more detailed information about the plan on the Fidelity website, www.401k.com or at my.robinsmorton.com.

401(K) CONTRIBUTION LIMITS

% of Salary	90%
Maximum	\$20,000
Over 50 catch up	\$6,500

401(K) VESTING SCHEDULE

Less than 2 years	0%
2 Years of service	20%
3 Years of service	40%
4 Years of service	60%
5 Years of service	80%
6 Years of service	100%



Check out WWW.401K.COM



Change your contributions



Review Investments



Update beneficiaries

Call 800.835.5097 for English or 800.587.5282 for Español.

Dependent Care Account (DCA)

Dependent Care Accounts run on a calendar year basis and what is not used during that time period will be lost. You use the account to pay for care of your dependents while you are at work.

PAYFLEX®

You can establish a Dependent Care Account (DCA) to pay for eligible child and adult care expenses like daycare, before and after school care, preschool, summer day camp, and in-home aid while you are at work. Funds are for your dependent(s) age 12 or younger, or a spouse or eligible dependent incapable of self-care.

The dependent must be able to be claimed as a dependent on the employee's federal tax return. You can contribute pretax dollars from your paycheck, up to the IRS limit of \$5,000. Claims for reimbursement can be filed online at www.payflex.com or by using the Payflex mobile app.

Limited Purpose Flexible Spending Account (LPFSA)

PAYFLEX®

- Contribute pretax dollars from your paycheck, up to the Internal Revenue Service (IRS) limit of \$2,750.
- Your full contribution is available at the start of the plan year.
- It works great with a health savings account (HSA) as it can help save your HSA dollars for future expenses.
- This is a limited benefit that can only be spent on dental and vision expenses. Any balance in the account at year end will be forfeited.
- Eligible expenses may include:
 - Dental and orthodontia care, fillings, X-rays and braces
 - Vision care, including eyeglasses, contact lenses and LASIK eye surgery.

Travel Connect Services

If you or your family become ill or have a medical emergency while away from home, this program provides you with 24/7 personal and emergency assistance with medical travel-related problems and circumstances.



Full time employees can access these services while traveling for business or personal reasons at least 100 miles from home for a period not exceeding 12 months in duration. Dependents traveling with the employee are also eligible. For a complete list of TravelConnect Services, go to mysearchlightportal.com and enter our group ID: LFGTravel123.



Care.com Membership

Make sure your loved ones have the care they need with a Care.com premium membership.

Care.com is an online caregiving platform that allows you to search, interview and screen caregivers to find the right care for your needs. With a care.com membership, it makes finding a caregiver easy. Robins & Morton is happy to cover the cost of the premium membership to ensure your family has the care it needs.

Please note that while Robins & Morton will cover the cost of a premium membership, employees will remain responsible for the actual cost of care.

Care.com services include:

- Background checks for caregivers
- Childcare
- Senior care
- Pet Care
- Test Prep
- Tutoring
- Housekeeping
- Daycare



To enroll in this benefit, purchase a membership and submit a reimbursement through Concur.



Business Travel Accident Insurance

Business Travel Accident insurance covers accidental death or dismemberment of Robins & Morton employees traveling on business.

All salaried employees are covered by this policy and it is fully paid by Robins & Morton. Eligible employees are covered 24 hours/day, worldwide, up to \$500,000. This coverage is in addition to other insurance you may have at the time of the accident.



Employee Assistance Program

We are pleased to have Behavioral Health Systems as the administrator of the Employee Assistance Program (EAP) for you and your family.



Behavioral Health Systems EAP will offer you and your family assistance with challenges affecting your home or work life. To utilize these services or to make an appointment, please contact Behavioral Health Systems at 1-800-245-1150.

This program is available to all full-time salaried employees and dependents with up to 6 free, confidential EAP Counseling Sessions. All counseling offered within the EAP is provided as a benefit by Robins & Morton. A simple call starts this process. If you would like to use this program, call Behavioral Health Systems at 1-800-245-1150.

The EAP program provides services in many areas, including:

- Marital and Family Issues
- Alcohol and Other Drug Dependency
- Stress Related Issues
- Financial/Legal Referrals
- Emotional Problems
- Personal Growth

HOW DOES IT WORK?

To access the EAP, call the number listed above. After taking some information about why you are calling, BHS will send you an email with a list of in-network therapist. You can research and pick which counselor would best fit your needs.

REMOVE THE STIGMA

While Behavioral Health Systems does provide counsel for areas like drug and alcohol abuse, they also have trained professionals who deal with normal, everyday struggles. If you're feeling stressed, overwhelmed, anxious or depressed, consider using the EAP to address it. Robins & Morton fully encourages employees and family members to seek counsel if it's needed. We care about your mental well-being and want you to know there's no shame in getting help.

TO ACCESS THE EAP, CALL:



1-800-245-1150



Saver Plan

SUMMARY OF COST SHARING PROVISIONS

(Includes Mental Health and Substance Abuse)

Benefit payments are based on the amount of the provider's charge that Blue Cross and/or Blue Shield plans recognize for payment of benefits. The allowed amount may vary depending upon type provider and where services are received. Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal Law.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible For individual coverage, no benefits, except preventive care, are paid by the plan until medical expenses paid by the individual equal the deductible amount. For family coverage, no benefits, except preventive care, are paid by the plan to a family member until that individual family member meets the individual deductible amount or the total medical expenses paid by the family equal the family deductible amount.	\$2,800 Individual \$5,000 Family Calendar year deductible amounts met in-network will not apply to out of network calendar year deductibles.	\$5,600 Individual \$10,000 Family Calendar year deductible amounts met in-network will not apply to out of network calendar year deductibles.
Calendar Year Out-of-Pocket Maximum All deductibles, copays and coinsurance for in-network and all deductibles, copays and coinsurance for out-of-network mental health disorders and substance abuse emergency services apply to the out-of-pocket maximum.	\$4,000 Individual \$8,000 Family After you reach your individual Calendar Year Out-of-pocket maximum (even if you are covered under family coverage), applicable expenses for you will be covered at 100% of the allowed amount for remainder of the calendar year. Note: The calendar year out-of-pocket maximum is combined for medical and prescriptions. Prescription drugs administered through CVS caremark.	There is no out-of-pocket maximum for out-of-network services
Prescription Drug Prescription drug benefits are not administered by Blue Cross and Blue Shield of Alabama		

HOSPITAL BENEFITS

Precertification is required for inpatient admissions (except medical emergency services and maternity and as required by Federal Law); notification within 48 hours for medical emergencies. General If precertification is not obtained, no benefits are available. Call 1-800-248-2342 (toll free) for precertification.

Inpatient Hospital Inpatient Physician Visits and Consultations Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 80%, subject to deductible	Covered at 60%, subject to deductible Note: In Alabama, in-patient hospital is available only for medical emergency services and accidental injury.
Emergency Room (Medical Emergency)	Covered at 80%, subject to deductible	Covered at 80%, subject to deductible Mental Health Disorders and Substance Abuse Services covered at 80% of the allowed amount, subject to in-network calendar year deductible
Emergency Room (Accident) Note: If you have a medical emergency as defined by the plan after 72 hours of an accident, refer to Emergency Room (Medical Emergency) above.	Covered at 80%, subject to deductible	Covered at 80%, subject to deductible, for services rendered within 72 hours Covered at 60%, subject to deductible, for services rendered after 72 hours and not a medical emergency as defined by the plan
Emergency Room (Physician)	Covered at 100%, subject to deductible	Covered at 100% of the allowed amount, subject to deductible Mental Health Disorders and Substance Abuse Services covered at 100% of the allowed amount, subject to in-network calendar year deductible
Chemotherapy, Dialysis, IV Therapy, Outpatient Diagnostic Lab, Pathology, Radiation Therapy & X-ray Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	Covered at 80%, subject to deductible	Covered at 60%, subject to deductible



Saver Plan

SUMMARY OF COST SHARING PROVISIONS

(Includes Mental Health and Substance Abuse)

PHYSICIAN BENEFITS

Precertification is required for some physician benefits; please see benefits booklet. Precertification is also required for provider-administered drugs; visit [AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList](https://alabamablue.com/ProviderAdministeredPrecertificationDrugList). If precertification is not obtained, no benefits are available.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Office Visits & Consultations	Covered at 80%, subject to deductible	Covered at 60%, subject to deductible
Second Surgical Opinion	Covered at 100%, subject to deductible	
Surgery & Anesthesia	Covered at 80%, subject to deductible	
Maternity Care		
Chemotherapy, Diagnostic Lab, Dialysis, IV Therapy, Pathology, Radiation Therapy & X-ray		
Applied Behavioral Analysis (ABA) Therapy		

PREVENTIVE CARE BENEFITS

Routine Immunizations and Preventive Services See AlabamaBlue.com/PreventiveServices for listing of specific immunizations and preventive services or call our Customer Service department for a printed copy Other Routine Screenings – once per calendar year with no age limitations: CBC, Cholesterol, Glucose, and Urinalysis. Routine OB/GYN Exam age 18+ (This is in addition to your annual PCP routine office visit)	Covered at 100%, no copay or deductible	Not covered
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Note: In some cases, office visit copays or facility copays may apply. Blue Cross and Blue Shield of Alabama will process these claims as required by Section 1557 of the Affordable Care Act.

OTHER COVERED SERVICES

Allergy Testing & Treatment Participating Chiropractic Services *Limited to 20 visits per member per calendar year Durable Medical Equipment (DME) Occupational, Physical and Speech Therapy *Limited to combined maximum 30 visits per member per calendar year. Unlimited visits for Autism Spectrum Disorders Medical Nutrition Therapy Services *For adults and children, limited to 6 hours per member per calendar year	Covered at 80%, subject to deductible	Covered at 60%, subject to deductible
Ambulance Service	Covered at 80%, subject to deductible	Covered at 80%, subject to deductible
Home Infusion	Covered at 100%, subject to deductible	Covered at 100%, subject to deductible
Home Health and Hospice	Covered at 100%, subject to deductible	Covered at 60%, subject to deductible



Saver Plan

SUMMARY OF COST SHARING PROVISIONS

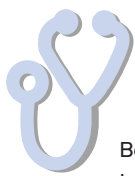
(Includes Mental Health and Substance Abuse)

HEALTH MANAGEMENT BENEFITS (Includes Mental Health Disorders and Substance Abuse)

Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231.
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and other specialized conditions.
Baby Yourself	A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at AlabamaBlue.com .
Contraceptive Management	Covers prescription contraceptives, which include: injectables, IUDs, and other non-experimental FDA approved contraceptives; subject to applicable deductibles, copays and coinsurance.

USEFUL INFORMATION TO MAXIMIZE BENEFITS

- To maximize your benefits, always use in-network providers for services covered by your health benefit plan. To find in-network providers, check a provider directory, provider finder website (AlabamaBlue.com) or call 1-800-810-BLUE (2583).
- In-network hospitals, physicians and other healthcare providers have a contract with a Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard PPO, PMD, Preferred Care). In-network pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or its Pharmacy Benefit Manager(s). In Alabama, in-network services provided by mental health disorders and substance abuse professionals are available through the Blue Choice Behavioral Health Network.
- Out-of-network providers generally do not contract with Blue Cross and/or Blue Shield Plans. If you use out-of-network providers, you may be responsible for filing your own claims and paying the difference between the provider's charge and the allowed amount. The allowed amount may be based on the negotiated rate payable to in-network providers in the same area or the average charge for care in the area.
- Please be aware that providers/specialists may be listed in a PPO directory or provider finder website, but not covered under this benefit plan. Please check your benefit booklet for more detailed coverage information.



Catastrophic Plan

SUMMARY OF COST SHARING PROVISIONS

(Includes Mental Health and Substance Abuse)

Benefit payments are based on the amount of the provider's charge that Blue Cross and/or Blue Shield plans recognize for payment of benefits. The allowed amount may vary depending upon type provider and where services are received. Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal Law.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible For individual coverage, no benefits, except preventive care, are paid by the plan until medical expenses paid by the individual equal the deductible amount. For family coverage, no benefits, except preventive care, are paid by the plan to a family member until that individual family member meets the individual deductible amount or the total medical expenses paid by the family equal the family deductible amount.	\$5,000 Individual \$10,000 Family Calendar year deductible amounts met in-network will not apply to out-of-network calendar year deductibles.	\$10,000 Individual \$20,000 Family Calendar year deductible amounts met in-network will not apply to out-of-network calendar year deductibles.
Calendar Year Out-of-Pocket Maximum All deductibles, copays and coinsurance for in-network and all deductibles, copays and coinsurance for out-of-network mental health disorders and substance abuse emergency services apply to the out-of-pocket maximum.	\$6,550 Individual \$13,100 Family After you reach your individual Calendar Year Out-of-pocket maximum (even if you are covered under family coverage), applicable expenses for you will be covered at 100% of the allowed amount for remainder of the calendar year. Note: The calendar year out-of-pocket maximum is combined for medical and prescriptions. Prescription drugs administered through CVS caremark.	There is no out-of-pocket maximum for out-of-network services
Prescription Drug Prescription drug benefits are not administered by Blue Cross and Blue Shield of Alabama		

HOSPITAL BENEFITS

Precertification is required for inpatient admissions (except medical emergency services and maternity and as required by Federal Law); notification within 48 hours for medical emergencies. General if precertification is not obtained, no benefits are available. Call 1-800-248-2342 (toll free) for precertification.

Inpatient Hospital Inpatient Physician Visits and Consultations	Covered at 70%, subject to deductible	Covered at 50%, subject to deductible
Precertification is required for some outpatient hospital benefits. Precertification is also required for provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList . If precertification is not obtained, no benefits are available.		
Outpatient Surgery (Including Ambulatory Surgical Centers)	Covered at 70%, subject to deductible	Covered at 50%, subject to deductible
		Covered at 70%, subject to deductible
Emergency Room (Medical Emergency)	Covered at 70%, subject to deductible	Mental Health Disorders and Substance Abuse Services covered at 80% of the allowed amount, subject to in-network calendar year deductible
Emergency Room (Accident)	Covered at 70%, subject to deductible	Covered at 70%, subject to deductible, for services rendered within 72 hours Covered at 50%, subject to deductible, for services rendered after 72 hours not a medical emergency as defined by the plan
Emergency Room (Physician)	Covered at 100%, subject to deductible	Covered at 100% of the allowed amount, subject to deductible Mental Health Disorders and Substance Abuse Services covered at 80% of the allowed amount, subject to in-network calendar year deductible
Chemotherapy, Dialysis, IV Therapy, Outpatient Diagnostic Lab, Pathology, Radiation Therapy & X-ray Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services	Covered at 70%, subject to deductible	Covered at 50%, subject to deductible



Catostrophic Plan

SUMMARY OF COST SHARING PROVISIONS

(Includes Mental Health and Substance Abuse)

PHYSICIAN BENEFITS

Precertification is required for some physician benefits. Precertification is also required for provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. If precertification is not obtained, no benefits are available.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Office Visits & Consultations	Covered at 70%, subject to deductible	Covered at 50%, subject to deductible
Second Surgical Opinion	Covered at 70%, subject to deductible	
Surgery & Anesthesia Maternity Care	Covered at 70%, subject to deductible	
Chemotherapy, Diagnostic Lab, Dialysis, IV Therapy, Pathology, Radiation Therapy & X-ray		
Applied Behavioral Analysis (ABA) Therapy		

PREVENTIVE CARE BENEFITS

Routine Immunizations and Preventive Services See AlabamaBlue.com/PreventiveServices for listing of specific immunizations and preventive services or call our Customer Service department for a printed copy Additional Preventative Screenings – once per calendar year with no age limitations: CBC, Cholesterol, Glucose, and Urinalysis. Routine OB/GYN Exam age 18+	Covered at 100%, no copay or deductible	Not covered
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Note: In some cases, office visit copays or facility copays may apply. Blue Cross and Blue Shield of Alabama will process these claims as required by Section 1557 of the Affordable Care Act.

OTHER COVERED SERVICES

Precertification is required for some other covered services. If precertification is not obtained, no benefits are available.

Allergy Testing & Treatment Participating Chiropractic Services *Limited to 20 visits per member per calendar year Durable Medical Equipment (DME) Occupational, Physical and Speech Therapy *Limited to combined maximum 30 visits per member per calendar year. Unlimited visits for Autism Spectrum Disorders Medical Nutrition Therapy Services *For adults and children, limited to 6 hours per member per calendar year	Covered at 70%, subject to deductible	Covered at 50%, subject to deductible
Ambulance Service	Covered at 70%, subject to deductible	Covered at 70%, subject to deductible
Home Health and Hospice	Covered at 100%, subject to deductible	Covered at 50%, subject to deductible
Home Infusion	Covered at 100%, subject to deductible	Covered at 100%, subject to deductible



Catostrophic Plan

SUMMARY OF COST SHARING PROVISIONS

(Includes Mental Health and Substance Abuse)

HEALTH MANAGEMENT BENEFITS (Includes Mental Health Disorders and Substance Abuse)

Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231.
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and other specialized conditions.
Baby Yourself	A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at AlabamaBlue.com .
Contraceptive Management	Covers prescription contraceptives, which include: injectables, IUDs, and other non-experimental FDA approved contraceptives; subject to applicable deductibles, copays and coinsurance.

USEFUL INFORMATION TO MAXIMIZE BENEFITS

- To maximize your benefits, always use in-network providers for services covered by your health benefit plan. To find in-network providers, check a provider directory, provider finder website (AlabamaBlue.com) or call 1-800-810-BLUE (2583).
- In-network hospitals, physicians and other healthcare providers have a contract with a Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard PPO, PMD, Preferred Care). In-network pharmacies are pharmacies that participate with Blue Cross and Blue Shield of Alabama or its Pharmacy Benefit Manager(s). In Alabama, in-network services provided by mental health disorders and substance abuse professionals are available through the Blue Choice Behavioral Health Network.
- Out-of-network providers generally do not contract with Blue Cross and/or Blue Shield Plans. If you use out-of-network providers, you may be responsible for filing your own claims and paying the difference between the provider's charge and the allowed amount. The allowed amount may be based on the negotiated rate payable to in-network providers in the same area or the average charge for care in the area.
- Please be aware that providers/specialists may be listed in a PPO directory or provider finder website, but not covered under this benefit plan. Please check your benefit booklet for more detailed coverage information.



VSP Vision Benefits

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
WellVision Exam	Focuses on your eyes and overall wellness	\$10	Every calendar year
Prescription Glasses		\$10	See frame and lenses
Frame	• \$150 allowance for a wide selection of frames • \$170 allowance for featured frame brands • 20% savings on the amount over your allowance • \$80 Walmart®/Costco® frame allowance	Included in Prescription Glasses	Every other calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every calendar year
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	\$0 \$95-\$105 \$150-\$175	Every calendar year
Contacts (Instead of glasses)	• \$150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to \$60	Every calendar year
Primary Eyecare	• As a VSP member, you can visit your VSP doctor for medical and urgent eyecare. Your VSP doctor can diagnose, treat, and monitor common eye conditions like pink eye, and more serious conditions like sudden vision loss, glaucoma, diabetic eye disease, and cataracts. Ask your VSP doctor for details.	\$20	As needed
PROTEC SAFETY® (EMPLOYEE-ONLY COVERAGE)			
Frame	• Fully covered when you choose a safety frame from your VSP doctor's ProTec Eyewear® collection • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	\$10 for frame and lenses	Every 24 months
Lenses	• Prescription single vision, lined bifocal, and lined trifocal • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	Combined with frame	Every 12 months
EXTRA SAVINGS			
Glasses and Sunglasses	• Extra \$20 to spend on featured frame brands. Go to vsp.com/offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
Retinal Screening	• No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam		
Laser Vision Correction	• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		



Met Life Indemnity Insurance

With MetLife, you'll have a choice of two comprehensive plans which provide payments in addition to any other insurance payments you may receive. Here are just some of the covered events/services. This plan does not cover accidents on the job.

BENEFIT	LOW PLAN PAYS YOU	HIGH PLAN PAYS YOU
HOSPITAL BENEFITS (ACCIDENT)		
Admission	\$500–\$1,000 per accident	\$1,000–\$2,000 per accident
Confinement (non-ICU confinement paid for up to 365 days. ICU confinement paid for 31 days)	\$100 (non-ICU)–\$200 (ICU) a day	\$200 (non-ICU)–\$400 (ICU) a day
Inpatient Rehab (paid per accident)	\$100 a day, up to 15 days	\$200 a day, up to 15 days
HOSPITAL BENEFITS (SICKNESS)		
Admission (payable 1x per calendar year)	\$500 – \$1,000 per sickness	\$1,000 – \$2,000 per sickness
Confinement (paid per sickness)	\$100 (non-ICU)–\$200 (ICU) a day (payable up to 31 days per sickness)	\$200 (non-ICU)–\$400 (ICU) a day (payable up to 31 days per sickness)



Met Life Accident Insurance

With MetLife, you'll have a choice of two comprehensive plans which provide payments in addition to any other insurance payments you may receive. Here are just some of the covered events/services. For full details, see the MetLife accident information on my.robinsmorton.com. This plan does not cover accidents on the job.

BENEFIT	LOW PLAN PAYS YOU	HIGH PLAN PAYS YOU
INJURIES		
Fractures	\$100–\$4,000	\$200–\$5,000
Dislocations	\$100–\$4,000	\$200–\$5,000
Second & Third Degree Burns	\$75–\$10,000	\$100–\$15,000
Concussions	\$250	\$500
Cuts/Lacerations	\$50–\$400	\$75–\$700
Eye Injuries	\$300	\$400
MEDICAL SERVICES & TREATMENT		
Ambulance	\$300–\$1,000	\$400–\$1,250
Emergency Care	\$75–\$150	\$100–\$200
Non-Emergency Care	\$75	\$100
Physician Follow-Up	\$75	\$100
Therapy Services (inc. physical therapy)	\$35	\$50
Medical Testing Benefit	\$150	\$200
Medical Appliances	\$75–\$750	\$150–\$1,000
Inpatient Surgery	\$150–\$1,500	\$200–\$2,000
ACCIDENTAL DEATH		
Employee receives 100% of amount shown, spouse receives 50% and children receive 20% of amount shown.	\$25,000 \$75,000 for common carrier	\$50,000 \$150,000 for common carrier
DISMEMBERMENT, LOSS, & PARALYSIS		
Dismemberment, Loss, & Paralysis	\$750–\$10,000 per injury	\$1,000–\$15,000 per injury

YOUR RIGHTS, LEGAL NOTICES, AND DISCLAIMERS

ROBINS & MORTON DISCLAIMER

This material is designed to highlight the features for the benefits program offered by Robins & Morton as of January 1 of the plan year noted on the cover. Where there may be discrepancies in this document, the plan documents will govern. If you would like to request a copy, please contact the HR department at (205) 803-0102. If you are a COBRA participant, and if you are eligible for, but not enrolled in Medicare due to being age 65 or older and the plan is secondary to Medicare, benefits payable under this plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare. The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense. If this plan is secondary to Medicare, the plan determines the amount it will pay for a covered health service by following the steps below:

- The plan determines the amount it would have paid less than the primary plan's allowable expense
- If this plan would have paid less than the primary plan paid, this plan pays no benefits
- If this plan would have paid more than the primary plan paid, this plan will pay the difference

The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

ELIGIBILITY DISCLAIMER

If an employee or dependent is found to not meet the eligibility criteria for the plan, the Plan Administrator is authorized to discontinue coverage and seek the return of claims paid by the plan and recommend personnel actions. Robins & Morton reserves the right to amend, modify or discontinue the plans at any time.

HIPAA SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards 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). In addition, if you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for

a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applies to most special enrollments.

To request special enrollment or obtain more information, contact the Robins & Morton HR Helpline 205.803.0102.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICES

Women's Health and Cancer Rights Act Notices If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, deductibles and coinsurance apply found in this booklet for your specific plan will apply.

If you would like more information on WHCRA benefits, call your plan administrator.

NOTICE OF THE ROBINS & MORTON EMPLOYEE BENEFIT PLAN HEALTH INFORMATION 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.

The effective date of this Notice of the Robins & Morton Employee Benefit Plan is October 1, 2021.

The Robins & Morton Employee Benefit Plan (the "Plan") provides health benefits to eligible employees of The Robins & Morton Group (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

For ease of reference, in the remainder of this Notice, the words "you," "your," and "yours" refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including employees and COBRA qualified

beneficiaries, if any, and their respective dependents.

Your "Protected Health Information" (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. Protected health information includes information of a person living or deceased (for a period of fifty years after the death.)

The Plan is required by law to provide notice to you of the Plan's duties and privacy practices with respect to your PHI and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice according to the Plan's distribution process. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

The Plan is distributing this Notice, and will distribute any revisions, only to participating employees and COBRA qualified beneficiaries, if any. If you have coverage under the Plan as a dependent of an employee, or COBRA qualified beneficiary, you can get a copy of the Notice by requesting it from the contact named at the end of this Notice.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor's or other health care provider's privacy practices with respect to your PHI that they maintain.

RECEIPT OF YOUR PHI BY THE COMPANY AND BUSINESS ASSOCIATES

The Plan may disclose your PHI to, and allow use and disclosure of your PHI by, the Company and Business Associates, and any of their subcontractors without obtaining your authorization.

Plan Sponsor

The Company is the Plan Sponsor and Plan Administrator. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the

Company a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice.

The Plan may disclose your PHI to the Company for plan administration functions performed by the Company on behalf of the Plan, if the Company certifies to the Plan that it will protect your PHI against inappropriate use and disclosure..

Example: The Company reviews and decides appeals of claim denials under the Plan. The Claims Administrator provides PHI regarding an appealed claim to the Company for that review, and the Company uses PHI to make the decision on appeal.

Business Associates

The Plan and the Company hire third parties, such as a third-party administrator (the "Claims Administrator"), to help the Plan provide health benefits. These third parties are known as the Plan's "Business Associates." The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or the Company to assist or carry out the terms of the Plan. In addition, these Business Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and the Company must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure and will require their subcontractors and agents to do so, too.

For purposes of this Notice, all actions of the Company and the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered maintained by the Plan. So, when this Notice refers to the Plan taking various actions with respect to health information, those actions may be taken by the Company or a Business Associate on behalf of the Plan.

HOW THE PLAN MAY USE OR DISCLOSE YOUR PHI

The Plan may use and disclose your PHI for the following purposes without obtaining your authorization. And, with only limited exceptions, we will send all mail to you, the employee. This includes mail relating to your spouse and other family members who are covered under the Plan. If a person covered under the Plan has requested Restrictions or Confidential Communications, and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

Your Health Care Treatment

The Plan may disclose your PHI for treatment (as defined in applicable federal rules) activities of a health care provider. Example: If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.

Example: The Plan might disclose information about your prior prescriptions to a pharmacist for the pharmacist's reference in determining whether a new prescription may be harmful to you. Making or Obtaining Payment for Health Care or Coverage: The Plan may use or disclose your PHI for payment (as defined in applicable federal rules) activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.

Example: The Plan will receive bills from physicians for medical care provided to you that will contain your PHI. The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying, benefits with respect to such a

bill. Example: The Plan may consider and discuss your medical history with a health care provider to determine whether a particular treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others.

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts)
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

The Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by the Company), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

Health Care Operations

The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities. Example: If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a disease management program.

Example: If claims you submit to the Plan indicate that the stop-loss coverage that the Company has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies. The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes.

- Quality assessment and improvement activities
- Disease management, case management and care coordination
- Activities designed to improve health or reduce health care costs
- Contacting health care providers and patients with information about treatment alternatives
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.
- The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.

- Underwriting (with the exception of PHI that is genetic information) premium rating and performing related functions to create, renew or replace insurance related to the Plan
- Planning and development, such as cost-management analyses
- Conducting or arranging for medical review, legal services, and auditing functions
- Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

The Plan also may use or disclose your PHI for purposes of assisting other health plans for which the Company is the plan sponsor, and any insurers and/or HMOs with respect to those plans, with their health care operations activities similar to both categories listed above. Limited Data Set: The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information. Legally Required: The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records. Health or Safety: When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others. The Plan can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence

Law Enforcement

The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.

Lawsuits and Disputes

In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.

Workers' Compensation

The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs. Emergency Situation: The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

Personal Representatives

The Plan will disclose your PHI to your personal representatives appointed by you or designated by

applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: 1) you have been or may be a victim of domestic abuse by your personal representative; or 2) recognizing such person as your personal representative may result in harm to you; or 3) it is not in your best interest to treat such person as your personal representative.

Public Health

To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

Health Oversight Activities

The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.

Coroner, Medical Examiner, or Funeral Director

The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.

Organ Donation

The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

Specified Government Functions

In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

Research

The Plan may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approves the research.

Disclosures to You

When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than Treatment, Payment, or Health Care Operations (and if you did not authorize the disclosure).

Authorization to Use or Disclose Your PHI

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact person named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.

Furthermore, we will not: (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations); (2) sell your confidential information (unless under strict legal restrictions) (to sell means to receive direct or indirect remuneration); (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization; or (4) use or disclose psychotherapy notes unless required by law.

Additionally, if a state or other law requires disclosure of immunization records to a school, written authorization is no longer required. However, a covered entity still must obtain and document an agreement which may be oral and over the phone.

The Plan May Contact You

The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail. You should note that the Plan may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

Your Rights With Respect to Your PHI

Confidential Communication by Alternative Means

If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

Request Restriction on Certain Uses and Disclosures

You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information,

its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

Right to Be Notified of a Breach

You have the right to be notified in the event that the plan (or a Business Associate) discovers a breach of unsecured protected health information.

Electronic Health Records

You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009. The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Paper Copy of This Notice

You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact person named at the end of this Notice.

Right to Access Your PHI

You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

Right to Amend

You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health

information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

Accounting

You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred more than six years before the date of your request, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice. Your request must state a time period which may not include dates more than six years before the date of your request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

Complaints

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Information

The Plan has designated Susie Brssher as its contact person for all issues regarding the Plan's privacy practices and your privacy rights. You can reach this contact person at: 400 Shades Creek Parkway, Birmingham AL 35209, 205.803.0109.

IMPORTANT NOTICE FROM ROBINS & MORTON ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

If you enroll in the Saver plan, there are two important

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Robins & Morton has determined that the prescription drug coverage offered by the Saver plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you enroll in the Catastrophic plan, there are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Robins & Morton has determined that the prescription drug coverage offered by the Robins & Morton is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Robins & Morton Employee Benefit Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from the Robins & Morton Employee Benefit Plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully—it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Robins & Morton coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Robins & Morton coverage, be aware that you and your dependents will not be able to get this coverage back.

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't

be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA – Medicaid

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

ARKANSAS – Medicaid

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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:
<https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/
State Relay 711
Health Insurance Buy-In Program (HIBI):
<https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program>
HIBI Customer Service: 1-855-692-6442

CALIFORNIA – Medicaid

Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 916-440-5676

FLORIDA – Medicaid

Website: <https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: <http://www.in.gov/fssa/hip/>
Phone: 1-877-438-4479
All other Medicaid
Website: <https://www.in.gov/medicaid/>
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: <https://dhs.iowa.gov/ime/members>
Medicaid Phone: 1-800-338-8366
Hawki Website: <http://dhs.iowa.gov/Hawki>
Hawki Phone: 1-800-257-8563

KANSAS – Medicaid

Website: <http://www.kdheks.gov/hcf/default.htm>
Phone: 1-800-792-4884

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

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

MAINE – Medicaid

Enrollment Website: <https://www.maine.gov/dhhs/ofi/applications-forms>
Phone: 1-800-442-6003
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

Website: <http://www.mass.gov/eohhs/gov/departments/masshealth/>
Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>
Phone: 1-800-657-3739

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/>
MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid

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

NEVADA – Medicaid

Medicaid Website: <https://dhcnp.nv.gov>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/oii/hipp.htm>

Phone: 603-271-5218

Toll free number for the HIPP program:
1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

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

NORTH CAROLINA – Medicaid

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

NORTH DAKOTA – Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

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

OREGON – Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: <https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx>
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

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

SOUTH CAROLINA – Medicaid

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

SOUTH DAKOTA – Medicaid

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

TEXAS – Medicaid

Website: <http://gethipptexas.com/>
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

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

VERMONT – Medicaid

Website: <http://www.greenmountaincare.org/>
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: <https://www.coverva.org/hipp/>
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

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

WEST VIRGINIA – Medicaid

Website: <http://mywvhipp.com/>
Phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

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

WYOMING – Medicaid

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

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20220 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

NEWBORN'S AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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 doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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 meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, 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.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered 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.

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 HR Helpline 205.803.0102.

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: Robins & Morton
4. Employer Identification Number (EIN) 63-1076743
5. Employer address: 400 Shades Creek Parkway
6. Employer phone number 205.870.1000
7. City Birmingham
8. State AL
9. Zip code 35209
10. Who can we contact about employee health coverage at this job? HR Helpline
11. Who can we contact about employee health coverage at this job? 205.803.0102
12. Email address AskHR@Robinsmorton.com

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

As your employer, we offer a health plan to:

- All employees. Eligible employees are:
 - Hourly employees
 - Salary employees

With respect to dependents:

We do offer coverage. Eligible dependents are:

- Your spouse, legally recognized and documented by a license or similar document from an appropriate jurisdiction. Common law marriages are not recognized;
- A married or unmarried child up to age 26, Children include:
 - Natural children
 - Step children
 - Legally adopted children
 - Children placed with the employee for adoption;
 - The employee's incapacitated, unmarried child, unable to support themselves and dependent upon the employee for support
 - A grandchild that meets all of the following criteria:
 - Under age 26
 - Unmarried
 - Resides in the same household full time in a parent-child relationship

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

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

How to Enroll

During Open Enrollment

(October 30 - November 10, 2021)

1	Go online to HR.ROBINSMORTON.NET
2	Log in to your Sage account.
3	Select "Open Enrollment" in the Benefits section of the left menu.
4	Follow the instructions and move between screens using the arrows at the top right.
5	Remember to select "I'm Finished" on the last screen.



You'll need to enter the dashes in your SSN when submitting your online enrollment.



You may enroll any time between October 30 - November 10, 2021.



We will not accept enrollments after November 10, 2021.

For New Hires Only

(30 days from date of hire)

1	Go online to HR.ROBINSMORTON.NET
2	Log in to your Sage account.
3	Select "Life Events," then "New Hire - Salary."
4	Follow the instructions and move between screens using the arrows at the top right.
5	Remember to select "I'm Finished" on the last screen.



You'll need to enter the dashes in your SSN when submitting your online enrollment.



You have 30 days from your hire date to enroll in benefits for the current year.

PLEASE NOTE!

A Benefits Enrollment Confirmation will be e-mailed to you once your elections have been approved.

Need Assistance?

The HR Helpline is available to assist you from 8:00 a.m. to 4:00 p.m. Central Standard Time Monday–Thursday and 8:00 a.m. to 2:00 p.m. Central Standard Time on Friday. You can also submit your questions at AskHR at my.robinsmorton.com



205.803.0102



my.robinsmorton.com

ROBINS & MORTON