

Hourly Team

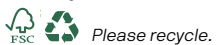
BENEFIT GUIDE

20
24



**Our people
are the heart
of our business.**

Printed on 100% post-consumer recycled fiber in a facility with net zero carbon emissions.



What's New for benefits in 2024

From our medical plan to our 401k profit sharing, our benefit programs go beyond traditional healthcare to bring you holistic wellness and security.

DEDUCTIBLE CHANGE The 2024 medical plan individual deductible will slightly increase due to IRS changes. The new deductible will be \$3,200 (individual). The family deductible of \$5,000 and out-of-pocket maximums will remain the same.

2024 MEDICAL PREMIUMS For 2024, the medical plan premium cost will slightly increase for the first time in 3 years by around \$2-\$3 on a weekly pretax basis for each coverage level.

2024 HSA IRS LIMITS The IRS has set the 2024 amount you may contribute to your HSA: individuals may contribute \$4,150, and families may contribute \$8,300. This total includes the annual Robins & Morton contribution. Team members 55+ years old may contribute an additional \$1,000. Manage your contributions through Fidelity at www.401k.com. Read more on page 12.

401K CONTRIBUTIONS The 2024 annual limits were not released when printing this guide.

NEW BENEFIT Robins & Morton is adding a clinical weight loss program through our vendor, Virta Health. Team members and dependents enrolled in the medical plan who meet the criteria will have free access to this program. Read more on page 15.

HR HELPLINE



Here to answer your questions

(205) 803-0102

- 8am to 4pm CST Monday–Thursday
- 8am to 2pm CST on Friday
- Messages checked daily



what
if I
don't
enroll?

existing team members

If you do not enroll during this time, **you will be re-enrolled in the same plan you had in 2024.** 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 2024. This does not carryover from year to year. Your next opportunity to enroll will be in the fall of 2024 during the Open Enrollment period for the 2025 plan year.

new hires

If you choose not to enroll, **you will not be covered for 2024.** You may enroll in benefits 90 days after your hire date. This is your eligibility date. You have 30 days from the eligibility date to enroll in benefits.



team members 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.

2024 checklist for open enrollment

MEDICAL PAGE 10

Waive or Select

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

HSAPAGE 12

Enroll in the HSA program

- Set contributions at 401k.com

DENTALPAGE 18

Waive or Select

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

VISIONPAGE 20

Waive or Select

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

SHORT TERM DISABILITYPAGE 21

Waive or Select

LONG TERM DISABILITYPAGE 21

Waive or Select LTD

ACCIDENT PAGE 22

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 23

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.

SPENDING ACCOUNTS PAGE 27

Dependent Care Account (DCA) page 27

- 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 27

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

BENEFITS SUMMARY

Print this page for your records



Visit my.robinsmorton.com for access to all things Robins & Morton's benefits. You will find helpful resources, tips, blogs and videos in order to ensure you're taking advantage of all we have to offer.

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FOR OFFICE USE ONLY:

Date Received: _____
Entered by: _____

Date Entered: _____
Username/Password: _____

Hourly Benefit Enrollment Form

Please complete this form and your elections will be entered in the system for you. You may return the completed form to the jobsite, email to rmenroll@robinsmorton.com or fax the form to 205-803-0102.

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Email Address _____

Phone Number _____ Alternate Phone Number _____

In the section below, please enter all dependents which will be covered in your benefits. If you need additional space, please add a page to this form. Do not include any dependent below that will not be covered.

MEDICAL INSURANCE

- WAIVE Medical Insurance
- Employee Only Employee + Spouse Employee + Children Family

COVERED DEPENDENTS

| NAME | RELATIONSHIP | SSN | DOB | ADDRESS | CITY | STATE | ZIP |
|------|--------------|-----|-----|---------|------|-------|-----|
| | | | | | | | |
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All dependents **MUST** have a social security number to be enrolled.

HEALTH SAVINGS ACCOUNT

Open your account and manage your contributions with Fidelity at www.401k.com

- WAIVE Health Savings Account Contribution

LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT

DISCLAIMER: Use it or lose it, and can only be used for dental and vision expenses.

- WAIVE Limited Purpose Flexible Spending Account Contribution

Amount: _____ per week (\$3,050 maximum yearly contribution or \$58.65 weekly maximum).

DEPENDENT CARE ACCOUNT

- WAIVE Dependent Care Flexible Spending

Amount: _____ per week (maximum of \$5,000.00 annually)

Please list the dependents to be covered by the dependent care flexible spending account:

| Name | |
|-------|-------|
| | |
| | |
| | |

DENTAL INSURANCE

- WAIVE Dental Benefit
- Employee Only Employee + Spouse Employee + Children Family

Please indicate which dependents listed above should be covered by dental insurance:

| Name | |
|-------|-------|
| | |
| | |
| | |

VISION INSURANCE

- WAIVE Vision Benefit
- Employee Only Employee + Spouse Employee + Children Family

Please indicate which dependents listed above should be covered by vision insurance:

| Name | |
|-------|-------|
| | |
| | |
| | |

SHORT TERM DISABILITY INSURANCE

- WAIVE Short Term Disability
- ELECT Short Term Disability

LONG TERM DISABILITY INSURANCE

- WAIVE Long Term Disability
- ELECT Long Term Disability



ACCIDENT INSURANCE

You can elect insurance on yourself, your spouse and your child(ren). Please indicate the plan level of coverage, who is covered then the beneficiaries of the policy.

WAIVE Accident Insurance

Level of Election – Accident Plan:

Low Plan High Plan

Employee Only Employee + Spouse Employee + Child Family

| Dependent Covered | Beneficiary | Primary % | Contingent % | SSN | DOB |
|-------------------|-------------|-----------|--------------|-----|-----|
| You | | | | | |
| Your dependent | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

INDEMNITY INSURANCE

WAIVE Hospital Indemnity Insurance

Level of Election – Indemnity Plan:

Low Plan High Plan

Employee Only Employee + Spouse Employee + Child Family

Please indicate which dependents listed above should be covered by indemnity insurance:

| Name |
|------|
| |
| |
| |

I understand Robins & Morton has offered the benefits on this enrollment form and acknowledge my selections.

Name: _____ Date: _____



Medical Plan



PLAN DESIGN: The plan limits out-of-pocket costs after meeting the deductible. The plan focuses on a very 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.

PRESCRIPTION DRUGS: Medical and Pharmacy claims, except generic preventive, accumulate toward the total out of pocket max of \$3,500 individual and \$6,500 family. Generic preventive drug copays are \$0.

OTHER COVERED EXPENSES: All other expenses are subject to a deductible. After you meet the deductible, the Plan will pay 80% of the cost. 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. An HSA can help you pay deductibles and coinsurance.

MENTAL HEALTH & SUBSTANCE ABUSE: Mental Health & Substance Abuse benefits are provided through Blue Cross Blue Shield as part of your health plan at no additional cost to you. These are covered at the same benefit level as the medical benefits.

COVERAGE: See page 31 for types of benefits associated with this plan.



2024

OUT-OF-POCKET COSTS FOR MEDICAL PLAN

| DEDUCTIBLE | | MEDICAL OUT-OF-POCKET MAX | |
|------------|---------|---------------------------|---------|
| Individual | Family | Individual | Family |
| \$3,200 | \$5,000 | \$3,500 | \$6,500 |

COST OF MEDICAL PLAN

| | EMPLOYEE ONLY | EMPLOYEE+SPOUSE | EMPLOYEE+CHILDREN | FAMILY |
|-----------------------|---------------|-----------------|-------------------|------------|
| Total Cost: | \$755.53 | \$ 1,618.85 | \$1,197.64 | \$1,762.93 |
| Robins & Morton Pays: | \$685.13 | \$1,463.75 | \$1,084.34 | \$1,593.53 |
| Monthly: | \$70.40 | \$155.10 | \$113.30 | \$169.40 |
| Weekly: | \$16.25 | \$35.79 | \$26.15 | \$39.09 |

Prescription Plan



medical

PLAN DESIGN: This plan encourages the use of generic and preferred brand drugs. We encourage you to discuss with your doctor and pharmacist the availability of generic preventive drugs for your maintenance conditions. 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/hourly/coverage/medical

PRESCRIPTION PLAN:

| | 1-34 DAYS SUPPLY | 90 DAY SUPPLY |
|--------------------|------------------|---------------|
| Generic Preventive | \$0 | \$0 |
| Generic Other | \$10 | \$25 |
| Preferred | \$30 | \$75 |
| Non-preferred | \$70 | \$175 |
| Specialty | \$150 | |

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 Papillomavirus | 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 | |



Health Savings Account



LEARN ABOUT THE HSA MATCH: Robins & Morton will match your weekly contribution dollar for dollar until your annual company contribution coverage tier limit has been reached. The company contribution is based on your enrollment in the medical plan. See the Robins & Morton contribution chart for details.

HOW TO OPEN AN HSA: After your enrollment has been processed, go to www.401k.com or call 1-800-544-3716 to open your account.

MANAGE YOUR HSA: Weekly contributions are managed and processed at www.401k.com.

HSA CONTRIBUTION LIMITS FOR 2024

| | SINGLE | FAMILY |
|------------------|---------|---------|
| TOTAL Limit | \$4,150 | \$8,300 |
| OVER 55 CATCH UP | \$1,000 | \$1,000 |

ROBINS & MORTON CONTRIBUTION

| YOUR ENROLLMENT | ANNUAL SEED MONEY |
|-------------------|-------------------|
| Employee Only | \$650 |
| Employee+Spouse | \$975 |
| Employee+Children | \$975 |
| Family | \$1,300 |

CALCULATE YOUR WEEKLY CONTRIBUTION



| YOUR FAMILY | EXAMPLE | YOU |
|---|----------------|-----|
| What is your TOTAL Limit? | \$8,300 | |
| Enter \$1,000 if you will be 55 or older on December 31, 2024 | \$1,000 | |
| SUBTOTAL | \$9,300 | |
| Subtract your annual seed money | (\$1,300) | |
| MAXIMUM ANNUAL CONTRIBUTION | \$8,000 | |
| Divide by 52 to find the maximum WEEKLY contribution | \$153.85 | |

Triple Tax Advantage

- ✓ You make contributions before taxes.
- ✓ You don't pay taxes when you pay for a qualified medical expense.
- ✓ You don't pay taxes on investments and interest earnings.

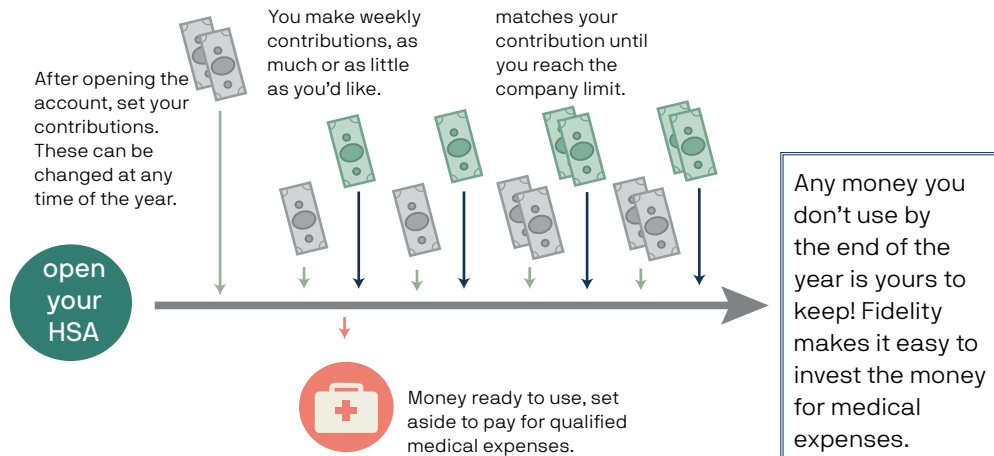


Health Savings Account FAQs



medical

HOW DOES IT WORK?



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).

FAQs

- WHO IS ELIGIBLE FOR THE HSA?**
Anyone enrolled in the medical plan is eligible to sign up for an HSA.
- WHEN CAN I SIGN UP?**
You can enroll and start contributing whenever you would like to, as long as you are enrolled in a Robins & Morton medical plan.
- HOW OFTEN CAN I CHANGE MY CONTRIBUTIONS?**
You can change your contributions at any point in the year and as many times as you'd like. Go to 401k.com to change your contributions.
- WHAT ABOUT THE MONEY I DON'T SPEND?**
The money you don't spend at the end of the year is yours to keep or invest. The balance will roll forward each year.

FOR MORE INFORMATION:

To learn more about investing your HSA, scan the QR code.





Telemedicine

ON THE GO CARE: 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 be prescribed medicines.

CONNECT ANYTIME, ANYWHERE: Contact a doctor wherever you are by calling 1-844-733-3627, visiting rm.amwell.com or connecting through the mobile Amwell application.



2024

Each telemedicine visit costs \$67

Teletherapy

ON THE GO THERAPY: Amwell also offers virtual therapy. This is an affordable, easy, and convenient way to consult with a mental health professional.

SERVICES: Amwell therapists provide care and counseling across several areas, including:

- Anxiety
- Depression
- Stress Management
- LGBTQ+ Counseling
- Bereavement/Grief
- OCD
- Panic Attacks
- Couples Therapy
- Panic Attacks
- Insomnia

CONNECT ONLINE: When you log into your Amwell, you'll find that Amwell has conveniently placed the therapy function next to the Medical Care option.



Make sure to enter Service Key **ROBINSMORTON** at enrollment.

For those enrolled in a medical plan, these charges count toward your deductible.



2024

Each teletherapy visit costs \$96 for a master's level therapist and \$122 for a doctoral level therapist.



Virta Health

PLAN DESIGN: 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 fully covers the cost of Virta for all team members, spouses, and adult dependents with type 2 diabetes, prediabetes, and/or a BMI of 30 or greater who are enrolled in a Robins & Morton 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.

ADDED BENEFIT FOR 2024: Through nutritional therapy and advanced telehealth, Virta's clinical weight loss program uses food as medicine to reverse weight gain. Members eat their way to better health with a nutrition plan made just for them and support from medical providers, coaches, and digital health tools. By shifting what they eat, not how much, members can quickly lose unwanted weight, lower A1C, and reduce medications. Virta's care plan includes:

- Personal provider care and coaching
- Scale, meter, and testing supplies
- Guidance to make go-to meals more healthy
- Daily support via the Virta app (mobile/desktop)

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



2024

Robins & Morton provides this service for you and your dependents covered by the medical plan.



After struggling with diabetes for 10 years, I started this program. Since then, I have lost 30 pounds, my blood sugar readings are below 100 and my Virta nurse practitioner told me to stop my diabetes medication.

- Robins & Morton team member



The tools and directions in the program have helped me lose weight and lower my blood sugar. I think anyone with type 2 diabetes could benefit from this program.

- Robins & Morton team member



medical



Vivante Health GI Thrive



PLAN DESIGN: GI Thrive focuses on improving gut health through a confidential, at-home program. This program comes with a GutCheck Microbiom Analysis, Registered Dietitians, Nutrition Guidance and Health Coaches.

HEALTH COACHES: GI Thrive health coaches specialize in stress management, goal setting, exercise, medication management and making positive changes last.

ELIGIBILITY: Team members and their dependents enrolled in a Robins & Morton medical plan are eligible for this service.

GETTING STARTED: To get started with GI Thrive, download the GI Thrive app or sign up at welcome.mygithrive.com/robinsmorton. For questions, call 1.833.336.9488 or email support@vivantehealth.com.

FEEL YOUR BEST: GI Thrive focuses on ways to help people feel their best with things like:

- How to identify GI symptom triggers
- How to manage GI symptoms at home
- Personal food plans, tailored to your body (including special diets to manager inflammatory bowel disease and IBS)
- Recipes and meal ideas to improve your gut health
- Proven methods for coping with stress and anxiety affecting your gut health

Note: This program is completely confidential. Privacy laws protect your personal information and protected health information (PHI). GI Thrive by Vivante Health is in strict compliance with these privacy laws and does not share PHI with anyone, including Robins & Morton. This program is not meant to replace your physician's treatment plan.

**Make sure to use
company code
ROBINS&MORTON
at enrollment.**



2024

Robins & Morton provides this service for you and your dependents covered by the medical plan.



Thank you for adding the GI Thrive benefit! I've had meetings with both the dietitian and health coach, both are wonderful. Best addition to all the ones we already have, a thousand thanks!

- Robins & Morton team member



I can finally make healthy living sustainable for the long-term.

- Robins & Morton team member



Hinge Health

Hinge Health specializes in reducing musculoskeletal (MSK) pain, surgeries, and opioid use.

Robins & Morton will fully cover the cost of Hinge for all team members and spouses enrolled in a Robins & Morton medical plan.

WHAT IS HINGE? Hinge Health is an at-home musculoskeletal physical therapy solution that allows members to work with a health coach and participate in knee, hip, spine, neck or shoulder sessions for chronic joint pain. The program is delivered remotely using mobile and wearable technology. Members 18 years and older are eligible to participate, but must be approved by Hinge Health through a questionnaire to determine if Hinge Health is the appropriate course of action for their chronic spine and joint pain.

HOW DOES IT WORK? The Hinge process begins with an initial PT video assessment. Members will join the call from the app. The physical therapist will then ask questions about symptoms, assess the home environment and perform a physical exam.

After the initial call, the physical therapist will customize a plan for the member containing types of exercises, length, reps, sessions per week and weekly progressions of exercise. This plan will be available on the app.

Members will also receive wearable sensors and a tablet that capture and interpret human movement and posture for form feedback and correction.

AVAILABLE PROGRAMS: Our Digital MSK Clinic (DMC) offering consists of FOUR programs:

Chronic Program - contains current program pathways for the following areas: Back, Knee, Hip, Shoulder and Neck, Women's Pelvic Health, Foot, Ankle, Elbow, Wrist and Hand.

Acute Program - for recent injury to any area

Surgery - for pre-/post-rehab

Prevention - job-specific exercises to reduce risk

GETTING STARTED: To get started with Hinge, go to hinge.health/robinsmorton.



2024

Robins & Morton provides this service for you and your dependents enrolled in the medical plan.

This benefit is offered to team members and dependents over age 18 enrolled in a Robins & Morton medical plan.

COMPLETE CLINICAL TEAM

- Physical therapists for physical recovery and personalized care
- Health coaches for lasting behavior change
- Surgeons and physicians for expert medical opinion

COMPREHENSIVE TECHNOLOGY

- Wearable sensors for real-time feedback *(please note, wearable sensors are only available to members of the Chronic program)*
- Advanced motion tracking with computer vision
- All-in-one app experience
- Integrated EMR data with HingeConnect

medical





Delta Dental




PLAN DESIGN: 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.

STAY CONNECTED: 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 to stay connected and find a provider. Delta Dental's oral health resources for tips and information that can help keep your smile healthy.

Delta Dental App

- Download the app by searching for Delta Dental.
- Review your plan details and find your delta dental card.



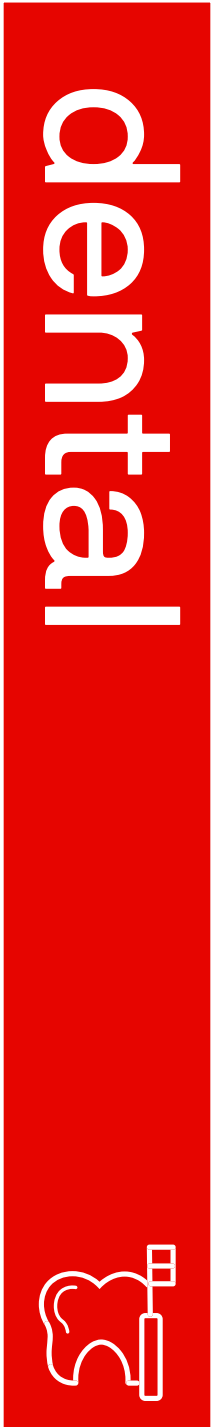

2024

DELTA DENTAL

| | EMPLOYEE ONLY | EMPLOYEE+SPOUSE | EMPLOYEE+CHILDREN | FAMILY |
|----------------------------------|---------------|-----------------|-------------------|--------|
| Total Cost: | \$21 | \$47 | \$45 | \$62 |
| Robins & Morton Pays: | \$10 | \$23 | \$22 | \$31 |
| Monthly: | \$11 | \$24 | \$23 | \$31 |
| Weekly: | \$2.54 | \$5.54 | \$5.31 | \$7.15 |

Para Delta Dental en Espanol, es.deltadentalins.com.

Delta Dental



Coverage

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 | 80% |
| Endodontics (root canals) covered under basic services | 80% |
| Periodontics (gum treatment) covered under major services | 50% |
| Oral surgery covered under basic services | 80% |
| Major Services: crowns, inlays, onlays and cast restorations, bridges and dentures | 50% |
| Prosthodontics: bridges and dentures | 50% |

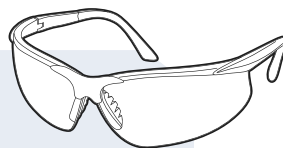
* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** 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.



PLAN DESIGN: 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!*



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.

VSP ONLINE: To view your vision benefits or find a doctor, go to vsp.com.

COVERAGE: Please refer to the plan matrix on page 34 for more details on coverage.



2024

VSP VISION PLAN

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

TRUHEARING MEMBER PLUS PROGRAM:

- Savings of up to 50% on hearing aids
- 48 batteries per purchased hearing aid
- Yearly comprehensive hearing exams for \$75
- 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.
- 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

No card to carry

VSP makes things easy by giving you one less insurance card to worry about.

When you go to the eye doctor, let them know you have VSP. They will search you by your name and social security number.



Short Term Disability



PLAN DESIGN: The Short Term Disability Plan provides financial protection for you by paying part of your salary if you become disabled. The amount you receive is based on your base salary when your disability began. This benefit is fully insured at Lincoln Financial and paid by your contributions. STD Insurance pays 60% of your base salary up to \$750 for days 6–90 of your disability.

COST: The cost of the insurance program depends on your income and your age as of January 1, 2024. The example below calculates premiums based on a \$750 benefit:

SHORT TERM DISABILITY

| AGE | UP TO-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65-69 |
|----------|----------|---------|---------|---------|---------|---------|---------|---------|----------|----------|
| Monthly: | \$55.50 | \$55.50 | \$55.50 | \$55.50 | \$55.50 | \$58.13 | \$72.00 | \$90.63 | \$110.13 | \$120.75 |
| Weekly: | \$12.81 | \$12.81 | \$12.81 | \$12.81 | \$12.81 | \$13.41 | \$16.62 | \$20.91 | \$25.41 | \$27.87 |

To start a Short Term Disability claim:

- contact your manager and your HR team
- complete the application
- make sure to include your doctor in the conversation
- in order to return to work, we will need a signed doctor's release

Long Term Disability



PLAN DESIGN: If you suffer a covered disability while insured by Long Term Disability Insurance, 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 with maximum of \$12,500 per month.

COST: The cost of the insurance program depends on your income and your age as of January 1 of the current year. The example below calculates premiums based on a monthly income of \$4,000.

LONG TERM DISABILITY

| AGE | UP TO-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65-69 |
|----------|----------|--------|--------|---------|---------|---------|---------|---------|---------|---------|
| Monthly: | \$3.12 | \$3.96 | \$7.56 | \$11.84 | \$17.72 | \$23.80 | \$32.96 | \$34.96 | \$36.92 | \$38.36 |
| Weekly: | \$0.72 | \$0.91 | \$1.74 | \$2.73 | \$4.09 | \$5.49 | \$7.61 | \$8.07 | \$8.52 | \$8.85 |

disability





Accident Insurance



PLAN DESIGN: Accident coverage makes 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.

COVERAGE: See page 35 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



2024

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



disability

PLAN DESIGN: 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.

ELIGIBILITY: 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.

COVERAGE: See page 35 for types of benefits associated with this plan.



2024

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 |





Employee Assistance Program



Your Employee Assistance Program (EAP) is a confidential assistance program to help address the personal issues you and your dependents are facing. This service, staffed by experienced clinicians, is available by phone 24 hours a day, seven days a week. A GuidanceConsultantSM is available to listen to your concerns and refer you to a local provider for in-person counseling or to resources in your community. Call any time with personal concerns, including:

- Depression
- Stress and anxiety
- Marital and family conflicts
- Alcohol and drug abuse
- Job pressures
- Grief and loss

FINANCIAL INFORMATION, RESOURCES AND TOOLS

Financial issues can arise at any time, from dealing with debt to saving for college. Our financial professionals are here to discuss your concerns and provide you with the tools and information you need to address your finances, including:

- Saving for college
- Tax questions
- Getting out of debt
- Estate planning
- Retirement planning

LEGAL INFORMATION, RESOURCES AND CONSULTATION

When a legal issue arises, our attorneys are available to provide confidential support with practical, understandable information and assistance. If you require representation, you can also be referred to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call any time with legal issues including:

- Divorce and family law
- Bankruptcy
- Debt obligations
- Criminal actions
- Landlord and tenant issues
- Civil lawsuits
- Real estate transactions
- Contracts

ONLINE INFORMATION, TOOLS AND SERVICES

GuidanceResources[®] Online is your one stop for expert information to assist you with the issues that matter to you, from personal or family concerns to legal and financial concerns. Create your own account by going to www.guidanceresources.com. Each time you return to the site, you will find personalized, relevant information based on your individual life needs. You can:

- Review in-depth HelpSheetsSM on topics you select
- Get answers to specific questions
- Search for services and referrals
- Use helpful planning tools



2024

You and your dependents are eligible to get five free counseling sessions per issue you may be facing. You must enroll in Short Term or Long Term Disability to be eligible for this benefit.

Retirement Savings Plan



401(k)

PLAN DESIGN: 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.

OPTIONS: 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.

PROFIT SHARING: The plan also has a profit sharing feature for team members 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.

ELIGIBILITY: All team members 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.

CAPTRUST: 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. See page 26 for more information.

401(K) CONTRIBUTION LIMITS

Note: The 2024 annual limits were not released when printing this guide.

| | |
|------------------|----------|
| % of Salary | 90% |
| Maximum | \$22,500 |
| Over 50 catch up | \$7,500 |

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 401k.com:



Change contributions



Review investments



Update beneficiaries

Or contact Fidelity at 800.835.5097



401(k)

Captrust Financial Advisors



CAPTRUST

FINANCIAL SERVICE: Captrust is our free financial advisory service. Captrust specializes in retirement blueprints, estate planning, and personal investment advice. Call or visit the website to book an appointment.

ELIGIBILITY: This service is available to all Robins & Morton team members.

PROCESS: After scheduling an appointment with Captrust online, they will request the form below to be filled out.

Provide your contact information:

| | |
|--|----------------------|
| First Name * | Last Name * |
| <input type="text"/> | <input type="text"/> |
| Email Address * | |
| <input type="text"/> | |
| Phone Number (do not enter 1 before the area code) * | |
| <input type="text"/> | |
| <input type="checkbox"/> Send text message notifications for this appointment | |
| Your Company Name * | |
| <input type="text"/> | |
| Additional Comments (Please do NOT include Social Security number or account information.) | |
| <input type="text"/> | |

Appointments

To book an appointment, call 800.967.9948 or go to captrustadvice.com and select a time slot.



2024

Robins & Morton covers the cost of this benefit.

Dependent Care Account (DCA)

PLAN DESIGN: 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 team member'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)

PLAN DESIGN: 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. Contribute pretax dollars from your paycheck, up to the Internal Revenue Service (IRS) limit of \$3,050.

ELIGIBLE 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, and vision care, including eyeglasses, contact lenses and LASIK eye surgery.

PAYFLEX®

USE IT OR LOSE IT

Both of these accounts operate on a **use it or lose it** basis. This means that any funds you don't use at the end of the year do not roll over into the next year.

Make sure to use your funds by the end of the year!

PAYFLEX®

other





Care.com Membership

PLAN DESIGN: 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. Please note that while Robins & Morton will cover the cost of a premium membership, team members will remain responsible for the actual cost of care.

SERVICES:

- Background checks for caregivers
- Childcare
- Pet care
- Senior care
- Tutoring
- Housekeeping
- And more!

Pet Insurance

PLAN DESIGN: We know pets are like family. When your pet needs to visit the vet, it can be stressful. Pet insurance pays a portion of your vet bills. We are happy to provide discounted premium rates for pet insurance through MetLife.

HOW DOES IT WORK?: Monthly premiums for pet insurance vary by animal type, breed and number of pets.

HOW TO ENROLL: To enroll, call 1-800-GET-MET8 or visit www.metlife.com/getpetquote. Pet insurance policies will have an effective date dependent on the date enrollment occurs.

The pet insurance process



Take your pet to any licensed vet. There's no network of providers to worry about.



Send MetLife your claim. Pay your bill at the vet and file a claim with MetLife. Be sure to include the invoice and vet records from the visit.



Get money back quickly. Most claims are processed in less than two weeks.



2024

Robins & Morton will reimburse the cost of the premium membership. Please expense the reimbursement through Concur.



Pet insurance can help cover:

- Lab work
- Surgery
- Medication
- Unexpected illnesses
- Unexpected accidents



2024

The cost is based on individual needs, animal type and breed. To get a quote, contact MetLife.

Benefit Cards and 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



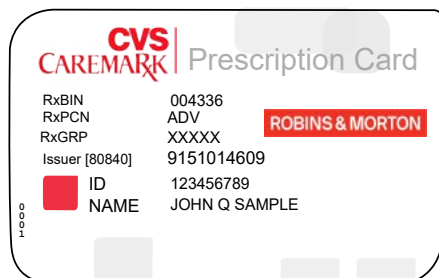
ALABAMA BLUE

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.



Website: <http://www.bcbsal.org>

Customer Service: 800.292.2262



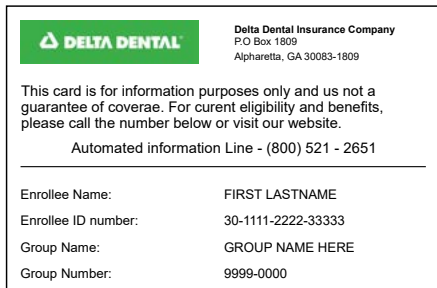
CVS CAREMARK

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.



Website: <http://www.cvs.com>

Customer Service: 800.334.8134



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.



Website: <http://www.deltadentalins.com>

Customer Service: 800.521.2651



NET BENEFITS

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.



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

Customer Service: 800.544.3716

Lost or stolen card: 888.377.0323



PAYFLEX MOBILE

Debit cards from PayFlex provide Robins & Morton team members with point-of-purchase access to their Limited Purpose Flexible Spending Account. Remember, you fund the LPPFA 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.



Website: <http://mypayflex.com>

Customer Service: 844.729.3539

Lost or stolen card: 844.729.3539



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>.



Website: <https://www.vsp.com>

Customer Service: 800.877.7195

Medical Plan

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 the type provider and where services are received.

HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account (HSA) is an account established with pre-taxed money in order to save for future medical expenses. In order to establish an HSA you must first be enrolled in an HSA-Qualified High Deductible Health Plan (HDHP). An HDHP is a health plan that satisfies certain government requirements for use in conjunction with a HSA. This plan is designed to meet those government requirements. Enrolling in an HDHP allows you the opportunity to make contributions to an HSA on a pre-tax basis.

Maximum Contribution: The maximum contribution amount is indexed each year by the U.S. Treasury. The 2024 maximum contribution is **\$4,150** for single coverage and **\$8,300** for family coverage. If you have any questions about the benefits of an HSA, please consult your tax accountant.

SUMMARY OF COST SHARING PROVISIONS

(Includes mental health and substance abuse)

| 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 any 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 | \$3,200 self-only coverage; \$5,000 family coverage Calendar year deductible amounts met in-network will not apply to the out-of-network calendar year deductible | \$6,000 self-only coverage; \$10,000 family coverage Calendar year deductible amounts met out-of-network will not apply to the in-network calendar year deductible |
| Calendar Year Out-of-Pocket Maximum All deductibles, copays and coinsurance for in-network services 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 | \$3,500 self-only coverage; \$6,500 family coverage 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 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. |

INPATIENT HOSPITAL AND PHYSICIAN BENEFITS

(Includes mental health and substance abuse)

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

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|--|
| Inpatient Hospital | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible Note: In Alabama, available only for medical emergency services and accidental injury. |
| Inpatient Physician Visits and Consultations | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible |

OUTPATIENT HOSPITAL BENEFITS

(Includes mental health and substance abuse)

Precertification is required for some outpatient hospital benefits; please see benefit booklet. 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 |
|---|--|--|
| Outpatient Surgery (Including Ambulatory Surgical Centers) | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible |
| Emergency Room (Medical Emergency) | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 80% of the allowed amount, subject to calendar year 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 80% of the allowed amount, subject to calendar year deductible | Covered at 80% of the allowed amount, subject to calendar year deductible |
| Emergency Room (Physician) | Covered at 100% of the allowed amount, subject to calendar year deductible | Covered at 100% of the allowed amount, subject to in-network calendar year 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 | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible |
| Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible |

Medical Plan continued

PHYSICIAN BENEFITS

(Includes mental health and substance abuse)

Precertification is required for some outpatient hospital benefits; please see benefit booklet. 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 and Consultations | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible |
| Second Surgical Opinions | Covered at 100% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible |
| Surgery & Anesthesia | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible |
| Maternity Care | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible |
| Chemotherapy, Diagnostic Lab, Dialysis, IV Therapy, Pathology, Radiation Therapy & X-ray | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible |
| Applied Behavioral Analysis (ABA) Therapy | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible |

TELEHEALTH SERVICES

Benefits are provided for Telehealth Services subject to applicable cost-sharing for in-network and out-of-network services, when services rendered are performed within the scope of the health care providers license and deemed medically necessary.

TELECONSULTATION SERVICES

Teleconsultation services will be provided by American Well and Blue Cross and Blue Shield of Alabama will process teleconsultation claims as In-Network. American Well contracted teleconsultation amount per consultation is \$67. Teleconsultation services for NON-COVID-19 claims will be covered at 100% of the allowed amount subject to a \$67 payment per consultation. Teleconsultation services for COVID-19 claims covered at 100% of the allowed amount, no copay or deductible.

PREVENTIVE CARE BENEFITS

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|--|---|----------------|
| 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 | Covered at 100% of the allowed amount, no copay or deductible | Not Covered |
| Other Routine Screenings Limited to once per calendar year with no age limitations: • Complete Blood Count • Cholesterol screening (to include total cholesterol, HDL, LDL, and Triglycerides) • Glucose test • Urinalysis | Covered at 100% of the allowed amount, no copay or deductible | Not Covered |
| Routine OB/GYN Exam One visit per calendar year for females age 18 and older (This is in addition to your annual PCP routine office visit) | Covered at 100% of the allowed amount, no copay or deductible | Not Covered |
| Additional HSA Preventive Medical Services Blood Pressure Monitor • One every 5 years for member diagnosed with hypertension Peak Flow Meter • One annually for member diagnosed with asthma International Normalized Ratio (INR) Testing • Maximum of 15 per year for member diagnosed with liver disorder and/or bleeding disorder Lipoprotein (LDL) Testing • Maximum of 5 per year for member diagnosed with heart disease Hemoglobin A1C Testing • Maximum of 4 per year for member diagnosed with diabetes Retinopathy Screening • Maximum of 3 per year for member diagnosed with diabetes | Covered at 100% of the allowed amount, no copay or deductible | Not Covered |

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.

Medical Plan continued

PRESCRIPTION DRUG BENEFITS

| | |
|--------------------|--|
| Prescription Drugs | Prescription drug benefits are covered through CVS Caremark. |
|--------------------|--|

BENEFITS FOR OTHER COVERED SERVICES

(Includes mental health and substance abuse)

Precertification is required for some other covered services; please see your benefit booklet. If precertification is not obtained, no benefits are available.

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|--|--|
| Allergy Testing & Treatment | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible |
| Ambulance Service | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 80% of the allowed amount, subject to calendar year deductible |
| Participating Chiropractic Services Limited to 20 visits per member per calendar year | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible |
| Durable Medical Equipment (DME) | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible |
| Rehabilitative Occupational, Physical and Speech Therapy • Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year • Unlimited Occupational, Physical and Speech Therapy for Autism Spectrum Disorders | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible |
| Habilitative Occupational, Physical and Speech Therapy • Occupational, physical and speech therapy limited to combined maximum of 30 visits per member per calendar year • Unlimited Occupational, Physical and Speech Therapy for Autism Spectrum Disorders | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible |
| Home Health and Hospice | Covered at 100% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible |
| Home Infusion | Covered at 100% of the allowed amount, subject to calendar year deductible | Covered at 100% of the allowed amount, subject to calendar year deductible |
| Medical Nutrition Therapy Services For adults and children, limited to 6 hours per member per calendar year | Covered at 80% of the allowed amount, subject to calendar year deductible | Covered at 60% of the allowed amount, subject to calendar year deductible |

HEALTH MANAGEMENT BENEFITS

(Includes mental health 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/BabyYourself . |
| 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). In Alabama, in-network services provided by mental health disorders and substance abuse professionals are available through the Blue Choice Behavioral Health Network. Sometimes an in-network provider may furnish a service to you that is not covered under the contract between the provider and a Blue Cross and/or Blue Shield Plan. When this happens, benefits may be denied or reduced. Please refer to your benefit booklet for the type of provider network that we determine to be an in-network provider for a particular service or supply.
- 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, the average charge for care in the area or in accordance with applicable Federal law.
- 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.

This is not a contract, benefit booklet or Summary Plan Description. Benefits are subject to the terms, limitations and conditions of the group contract (including your benefit booklet). Check your benefit booklet for more detailed coverage information. Please visit our website, AlabamaBlue.com.

Vision Plan

SUMMARY OF BENEFITS

YOUR COVERAGE WITH A VSP PROVIDER

| BENEFIT | DESCRIPTION | COPAY | FREQUENCY |
|-------------------------------|---|----------------------------------|---------------------------|
| WellVision Exam | Focuses on your eyes and overall wellness | \$10 | Every calendar year |
| Prescription Glasses | | \$10 | See frames and lenses |
| Frame | <ul style="list-style-type: none"> \$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 | <ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children | Included in Prescription Glasses | Every calendar year |
| Lens Enhancements | <ul style="list-style-type: none"> 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) | <ul style="list-style-type: none"> \$150 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation) | Up to \$60 | Every calendar year |
| Primary Eyecare | <ul style="list-style-type: none"> 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)

| BENEFIT | DESCRIPTION | COPAY | FREQUENCY |
|---------|--|---------------------------|-----------------|
| Frame | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> 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. |
| Retinol Screening Enhancements | <ul style="list-style-type: none"> No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam |
| Laser Vision Correction | <ul style="list-style-type: none"> Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities |

Accident

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-\$1000 |
| 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 |
|----------------------------------|---------------------------|-----------------------------|

Indemnity

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) |

Glossary

BRAND NAME PRESCRIPTION DRUGS

This drug is protected by patent and can only be given to you with a prescription. You will pay a higher price for these drugs than for Generic drugs because there is no competition in the manufacture of these drugs.

COBRA

Consolidated Omnibus Budget Reconciliation Act of 1986—A law that permits individuals to continue coverage temporarily under most employer health insurance plans when they would otherwise lose eligibility due to a loss of employment or a change in family status (such as divorce). The cost of this continued coverage is fully paid by the team member or dependent that elects it.

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 this 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.

COINSURANCE

The percentage of the cost for covered medical services paid by the patient under the health plan, after first meeting the applicable plan deductible.

DEPENDENT

For the Robins & Morton plan, your eligible dependents include:

- 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 and legally adopted children
 - Children placed with the team member for adoption;
 - The team member's incapacitated, unmarried child, unable to support themselves and dependent upon the team member 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

GENERIC PRESCRIPTION DRUGS

When the patent on a brand-name drug expires, other companies are allowed to manufacture the same drug creating a competitive price. This is called a Generic drug. It contains the same chemicals as the brand-name drug, but generic drugs usually cost less. They are sold under the scientific name of the drug, not the advertised brand name.

IN-NETWORK

Healthcare providers who participate in the Blue Cross Blue Shield network of contracted providers for the Robins & Morton health plan.

MEDICAL DEDUCTIBLE

The annual amount you pay out-of-pocket for covered medical services and prescription drugs before your plan begins paying.

OUT-OF-NETWORK

Healthcare providers who do not participate in the Blue Cross Blue Shield network of contracted providers for the Robins & Morton's health plan.

OUT-OF-POCKET

Expenses such as copayments and deductibles that an individual is required to contribute toward the cost of health services covered by his or her health benefits plan. You might consider participating in a Flexible Spending Account or Health Savings Account to save taxes on out-of-pocket expenses.

OUT-OF-POCKET MAXIMUM

The annual cap on what you will pay for covered in-network services, including your deductible and any coinsurance.

PREVENTIVE GENERIC

The Federal government prepares a list of preventive generic drugs that you can obtain at a lower price without meeting the deductible.

YOUR RIGHTS, LEGAL NOTICES, AND DISCLAIMERS

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.
- 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

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. The applicable deductibles and coinsurance

amounts are included in this booklet for your specific plan.

If you would like more information on WHCRA benefits, call your plan administrator 205.803.0102.

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.

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, 2023.

The Robins & Morton Employee Benefit Plan (the "Plan") provides health benefits to eligible team members 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 team members 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 team members 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 team members 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. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you 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 Brasher 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 Hourly 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 Hourly 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.

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, 2023. 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: <https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid

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

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
Website: <http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

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

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/hcpcf/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/
State Relay 711
Health Insurance Buy-In Program (HIBI):
<https://www.mycohibi.com/>
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.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, Press 1
GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid

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

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
HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

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

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.ldh.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
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
<https://www.maine.gov/dhhs/ofi/applications-forms>
Phone: -800-977-6740.
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>
Phone: 1-800-862-4840
TTY: (617) 886-8102
Email: masspreassistance@accenture.com

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
Email: HHSHIPProgram@mt.gov

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://dhcftp.nv.gov>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 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.nifamilycare.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: <https://www.hhs.nd.gov/healthcare>
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>
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx>
Phone: 1-800-692-7462
CHIP Website: <https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite 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: <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>
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: <https://dvha.vermont.gov/members/medicaid/hipp-program>
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>
Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

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

WEST VIRGINIA – Medicaid and CHIP

Website: <https://dhr.wv.gov/bms/>
Website: <http://mywvhipp.com/>
Medicaid Phone: 304-558-1700
CHIP Toll-free 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/medicaid/programs-and-eligibility/>
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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 20210 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. Phone number (if different from above) 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 team members. Eligible team members are:
 - Hourly team members
 - Salary team members

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. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

How to Enroll

hr.robinsmorton.net

During Open Enrollment

(October 28 - November 8, 2023)

- 1 Go online to hr.robinsmorton.net
- 2 Log in to your Sage account.
- 3 Select “Benefits,” then “Open Enrollment.”
- 4 Follow the instructions and move between screens using the next button.
- 5 Remember to select “I’m Finished” on the last screen.

✓ We will not accept enrollments after November 8, 2023.

For New Hires

(eligibility begins 90 days after hire date.)

- 1 Go online to hr.robinsmorton.net
- 2 Log in to your Sage account.
- 3 Select “Benefits,” then “Life Events.” Then select “New Hire - Hourly.”
- 4 Follow the instructions and move between screens using the next button.
- 5 Remember to select “I’m Finished” on the last screen.

✓ Your eligibility begins 90 days after your hire date. You have 30 days from your eligibility date to enroll in benefits for the current year.

PLEASE NOTE: A benefits enrollment confirmation will be emailed to you once your elections have been approved. Please make sure you have received this email.



ROBINS & MORTON

400 Shades Creek Parkway
Birmingham, AL 35209

OPEN ENROLLMENT

OCTOBER 28–NOVEMBER 8

 For detailed instructions on how to enroll, see page 43.