ROBINS & MORTON

Salary Team

BENEFIT GUIDE

2025

my.robinsmorton.com

Our people are the heart of our business.

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

Please recycle.

What's New

for benefits in 2025

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 2025 Saver Plan individual deductible will increase slightly due to IRS changes. The new deductible will be $3,300 (individual). The family deductible of $5,000 will remain the same as well as all out-of-pocket maximums. There are no changes to the Catastrophic Plan.

2025 HSA IRS LIMIT

The IRS has set the 2025 amount you may contribute to your HSA: individuals may contribute $4,300, and families may contribute $8,550. 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 10.

401K CONTRIBUTIONS

The 2025 annual limits were not released at the time of printing this guide.

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 2025. This does not carryover from year to year. Your next opportunity to enroll will be in the fall of 2025 during the Open Enrollment period for the 2026 plan year.

new hires

If you choose not to enroll, **you will not be covered for 2025**. You may enroll in benefits upon hire date. This is your eligibility date. You have 30 days from the eligibility date to enroll in benefits.

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.

my.robinsmorton.com

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.

2025 CHECKLIST

for open enrollment

☐ **COMPANY PAID LIFE & AD&D** ..... **PAGE 24**

Is your beneficiary information up-to-date?

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

☐ **SAVER** ..... **PAGE 8**

Waive or Select

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

☐ **CATASTROPHIC** ..... **PAGE 9**

Waive or Select

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

☐ **HSA** ..... **PAGE 10**

Enroll in the HSA program

- Set contributions at 401k.com

☐ **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.

☐ **DENTAL** ..... **PAGE 18**

Waive or Select

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

☐ **VISION** ..... **PAGE 20**

Waive or Select

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

☐ **EMPLOYEE OPTIONAL LIFE** ..... **PAGE 24**

Waive or Select

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

☐ **SPOUSE OPTIONAL LIFE** ..... **PAGE 24**

Waive or Select

- Coverage amount: if this is your first time electing this benefit, you can only elect $10,000 in coverage. You can step up to the next coverage level if you had this benefit in 2024. Contingent beneficiaries are optional.
- Elect beneficiaries: percentages must add up to 100%. Contingent beneficiaries are optional.

☐ **CHILD OPTIONAL LIFE** ..... **PAGE 24**

Waive or Select

- Coverage amount: $10,000
- Elect beneficiaries: percentages must add up to 100%. Contingent beneficiaries are optional.

☐ **LONG TERM DISABILITY** ..... **PAGE 21**

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

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

☐ **ACCIDENT** ..... **PAGE 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.

☐ **BENEFITS SUMMARY**

Print this page for your records

contents

medical

Saver Plan

BlueCross BlueShield

PLAN DESIGN: The plan focuses on a low premium in return for reasonable point of service costs and provides a large incentive to act as consumers of healthcare using your Health Savings Account.

PREVENTIVE CARE: The plan pays 100% of the cost of preventive care for each covered member of your family. This ensures that you can get the regular check-ups and tests recommended for your age and gender.

PRESCRIPTION DRUGS: Medical and pharmacy claims 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.

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

You might enroll in this plan if you prefer:

- Paying **MORE** out of your weekly check towards insurance
- Paying **LESS** out of pocket at the point of service to meet the deductible and out of pocket maximums

2025

OUT-OF-POCKET COSTS FOR SAVER PLAN

DEDUCTIBLE		MEDICAL OUT-OF-POCKET MAX	
Individual	Family	Individual	Family
$3,300	$5,000	$3,500	$6,500

COST OF SAVER 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

Catastrophic Plan

BlueCross BlueShield

medical

PLAN DESIGN: This plan limits your out-of-pocket costs after meeting the deductible. The plan focuses on a low level of coverage with no contributions, leaving the risk for most healthcare expenses with you.

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 $6,000 individual and $12,000 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 70% 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.

COVERAGE: Please refer to the plan matrix on page 37 for more details.

You might enroll in this plan if you prefer:

- Paying **LESS** out of your weekly check towards insurance
- Paying **MORE** out of pocket at the point of service to meet the deductible and out of pocket maximums

2025

OUT-OF-POCKET COSTS FOR CATASTROPHIC PLAN

DEDUCTIBLE		MEDICAL OUT-OF-POCKET MAX	
Individual	Family	Individual	Family
$5,000	$10,000	$6,000	$12,000

COST OF CATASTROPHIC PLAN

	EMPLOYEE ONLY	EMPLOYEE+SPOUSE	EMPLOYEE+CHILDREN	FAMILY
Total Cost:	$688.16	$1,470.43	$1,089.22	$1,600.81
Robins & Morton Pays:	$688.16	$1,470.43	$1,089.22	$1,600.81
Monthly:	$0	$0	$0	$0
Weekly:	$0	$0	$0	$0

medical

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 2025

	SINGLE	FAMILY
TOTAL Limit	$4,300	$8,550
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?	$8,550	
Enter $1,000 if you will be 55 or older on December 31, 2024	$1,000	
SUBTOTAL	**$9,550**	
Subtract your annual seed money for family coverage	($1,300)	
MAXIMUM ANNUAL CONTRIBUTION	**$8,250**	
Divide by 52 to find the maximum WEEKLY contribution	$158.65	

Triple Tax Advantage

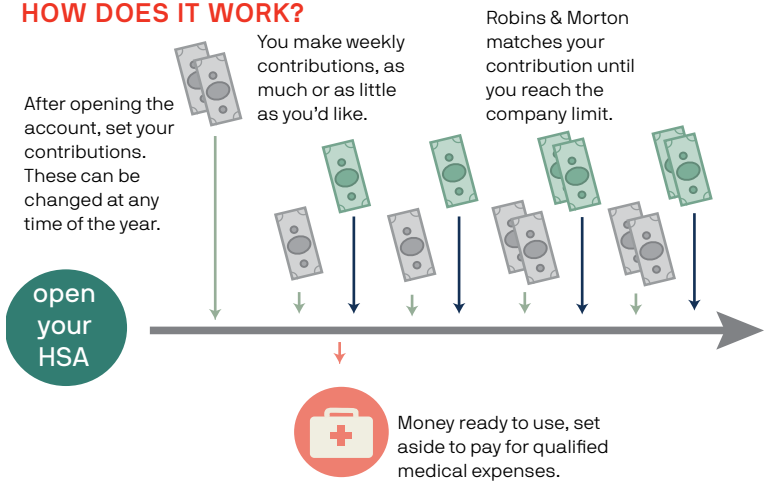
- You make contributions before taxes.
- You don't pay taxes when you pay for a qualified medical expense.
- You don't pay taxes on investments and interest earnings.

Health Savings Account FAQs

Fidelity INVESTMENTS

medical

HOW DOES IT WORK?



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

HOW DO YOU INVEST IT?

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

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

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.

medical

Prescription Plan

CVS caremark®

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/salary/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	Diptheria, Tetanus	Rotavirus	Hepatitis B	Pneumonia	Hepatitis A & B
Measles, Mumps, Rubella, Varicella	Haemophilus B, Hepatitis B	Meningiococcal, Haemophilus B, Tetanus	Measles, Mumps, Rubella	Human Papillomavirus	Tetanus, Diptheria Toxoids
Diptheria, Tetanus, Pertussis, Haemophilus B	Diptheria, Tetanus, Pertussis, Inactivated Poliovirus	Diptheria, Tetanus, Pertussis	Meningiococcal	Hepatitis A	Zoster (Zostavax)
Diptheria, Tetanus, Pertussis, Inactivated Poliovirus, Haemophilus B	Diptheria, Tetanus, Pertussis, Inactivated Poliovirus, Hepatitis B	Inactivated Poliovirus	Varicella, COVID-19	Influenza	

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.

Make sure to enter Service Key ROBINSMORTON at enrollment.

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

2025

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
- 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.

2025

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

medical

medical

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.

WEIGHT LOSS PROGRAM: 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.

virta

2025

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

Cylinder

Cylinder

medical

PLAN DESIGN: Cylinder focuses on improving gut health through a confidential, at-home program. This program comes with a GutCheck microbiome analysis, registered dietitians, nutrition guidance and health coaches.

HEALTH COACHES: Cylinder 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 Cylinder, download the Cylinder app or sign up at go.cylinderhealth.com/robinsmorton. For questions, call 1.833.336.9488 or email support@cylinderhealth.com.

FEEL YOUR BEST: Cylinder 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 manage 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). Cylinder 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.

2025

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

> Thank you for adding the Cylinder 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

medical

GRAIL

In partnership with GRAIL, Robins & Morton is pleased to offer eligible team members the Galleri multi-cancer early detection test at no cost. The Galleri test and detects a cancer signal across more than 50 types of cancer.

HOW DOES IT WORK? Through a simple blood draw, the Galleri test looks at DNA in your blood to determine if any of it may have come from cancer cells. GRAIL's Galleri test does not detect all cancers and should be used in addition to routine cancer screening tests recommended by a healthcare provider.

ELIGIBILITY CRITERIA: The Galleri test is being offered to team members and their dependents aged 50 years or older, or 35-49 with certain risk factors, enrolled in a medical plan.

The Galleri test is intended to be used in addition to, and not replace, other cancer screening tests your healthcare provider recommends. The test does not measure your genetic risk of developing cancer in the future.

GETTING STARTED: Register and order a test at www.galleri.com/robinsmorton

UNDERSTANDING THE RESULTS:

No Cancer Signal Detected

This means that no cancer signal was found; however, not all cancers can be detected by the Galleri test. Be sure to continue with routine recommended cancer screening tests. Missing routine cancer screenings or ignoring symptoms could lead to a delayed diagnosis of cancer.

Cancer Signal Detected

This means that there are signals associated with cancer were detected. Your healthcare provider will discuss appropriate follow-up tests to confirm if cancer is present. The Galleri test does not diagnose cancer.

False negative and false positive results do occur.

GRAIL

2025

Robins & Morton covers the cost of this service for team members enrolled in a medical plan.

Key benefits of the Galleri test:

- **EARLY CANCER DETECTION** Detects many cancers not commonly screened for today, to allow for earlier treatment
- **TESTING WITH EASE** Completed with a simple blood draw
- **ACTIONABLE RESULTS** If a cancer signal is found, the results point to where the cancer is coming from with high accuracy

FOR TEAM MEMBERS NOT ENROLLED IN A MEDICAL PLAN:

For team members not enrolled in a medical plan who wish to use GRAIL, the cost of this service is $949 paid directly to GRAIL.

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.

Hinge Health™

2025

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

dental

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

2025

Robins & Morton covers the cost of this benefit for those who register for it.

DELTA DENTAL

	EMPLOYEE ONLY	EMPLOYEE+SPOUSE	EMPLOYEE+CHILDREN	FAMILY
Total Cost:	$30	$68	$65	$89
You Pay:	$0	$0	$0	$0

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

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	100%
Endodontics (root canals) covered under basic services	100%
Periodontics (gum treatment) covered under major services	50%
Oral surgery covered under basic services	100%
Major Services: crowns, inlays, onlays and cast restorations, bridges and dentures	50%
Orthodontic Benefits for dependent children	50%
Orthodontic Maximum, Lifetime (per child)	$1,500 Lifetime up to age 19
Prosthodontics: bridges and dentures	50%

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

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

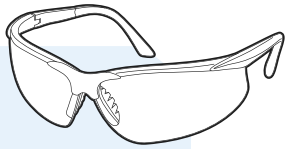
dental

vision

VSP

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 40 for more details on coverage.

2025

Robins & Morton covers the cost of this benefit.

TRUHEARING MEMBER PLUS PROGRAM:

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

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.

VSP VISION PLAN

YOU PAY	EMPLOYEE ONLY	EMPLOYEE+SPOUSE	EMPLOYEE+CHILDREN	FAMILY
Monthly:	$7.36	$12.64	$12.88	$20.26
You Pay:	$0	$0	$0	$0

Short Term Disability

ROBINS & MORTON

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

ELIGIBILITY: Please refer to the guidelines posted on my.robinsmorton.com. This benefit pays a maximum of 90 days in a rolling 12 month period.

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

Prudential

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

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

disability

Accident Insurance

MetLife

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 41 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

2025

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

MetLife

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 41 for types of benefits associated with this plan.

2025

RATES – LOW PLAN

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

RATES – HIGH PLAN

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

Basic Life and AD&D

Prudential

PLAN DESIGN: Robins & Morton provides basic life insurance to all salaried team members. Accidental Death & Dismemberment (AD&D) coverage is also included that can pay up to double the basic life insurance coverages.

COVERAGE TIER: Each team member's coverage tier is based on their salary.

2025

Robins & Morton covers the cost of this benefit.

BASIC LIFE AND AD&D INSURANCE

SALARY	BASIC LIFE	AD&D
Up to $25,000	$25,000	$25,000
$25,000.01–$50,000	$50,000	$50,000
$50,000.01–$75,000	$75,000	$75,000
$75,000.01–$100,000	$100,000	$100,000
$100,000–$300,000	$250,000	$250,000
Over $300,000	$350,000	$350,000

Optional Life and AD&D Insurance

Prudential

PLAN DESIGN: You can elect life insurance coverage at several levels with a maximum of $250,000. With optional life, you will receive an equal amount of Accidental Death & Dismemberment coverage to help pay expenses if you or your spouse are seriously injured or killed in a covered accident.

DEPENDENTS: You may also elect $10,000, $25,000 or $50,000 of optional life insurance for your spouse. Optional life insurance for your unmarried, dependent children is also available with one policy covering all eligible children.

EVIDENCE OF INSURABILITY: If you apply for more than $200,000, you will be required to provide evidence of insurability. This form is available by contacting the HR Helpline. You will not be covered for the optional life over the guaranteed amount until this form is submitted and approved. The cost of both team member and spousal coverage are based on your age as of January 1 of the current year.

Reminder

Make sure to include beneficiaries when enrolling in benefits. All life insurance policies require them.

When adding your spouse or dependents as beneficiaries, please list their Type as "both."

Retirement Savings Plan

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.

Fidelity INVESTMENTS

401(K)

401(K) CONTRIBUTION LIMITS

% of Salary	90%
Maximum	$23,000
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 *

Email Address *

Phone Number (do not enter 1 before the area code) *

Send text message notifications for this appointment

Your Company Name *

Additional Comments (Please do NOT include Social Security number or account information.)

Appointments

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

2025

Robins & Morton covers the cost of this benefit.

Dependent Care Account (DCA)

inspira FINANCIAL

other

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 Inspira mobile app.

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!

Limited Purpose Flexible Spending Account (LPFSA)

inspira FINANCIAL

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 $3,200.

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.

Employee Assistance Program

BEHAVIORAL HEALTH SYSTEMS

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

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

COVERAGE: The EAP provides services in many areas, including:

- Marital and family issues
- Alcohol and other drug dependency
- Stress related issues
- Financial/legal referrals
- Emotional problems
- Personal growth

REMOVE THE STIGMA: If you're feeling stressed, overwhelmed, anxious or depressed, consider using the EAP to address it. Robins & Morton fully encourages team members and family members to seek counsel if it's needed. We care about your mental well-being and want you to know **there's no shame in getting help.**

2025

You and your dependents are eligible to get six free counseling sessions per issue you may be facing.

Travel Assistance Services

Prudential

PLAN DESIGN: If you or your family become ill or have a medical emergency while away from home, Travel Assistance Services through Prudential provides you with 24/7 personal and emergency assistance with medical travel-related problems and circumstances.

ELIGIBILITY: Full-time team members can access these services while traveling for business or personal reasons at least 100 miles from home and for fewer than 90 consecutive days. Dependents traveling with the team member are also eligible.

2025

Robins & Morton covers the cost of this benefit.

Business Travel Accident Insurance

ZURICH

PLAN DESIGN: Business Travel Accident insurance covers accidental death or dismemberment of Robins & Morton team members traveling on business.

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

2025

Robins & Morton covers the cost of this benefit.

other

Pet Insurance

MetLife

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.

Pet insurance can help cover:

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

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.

2025

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

Care.com Membership

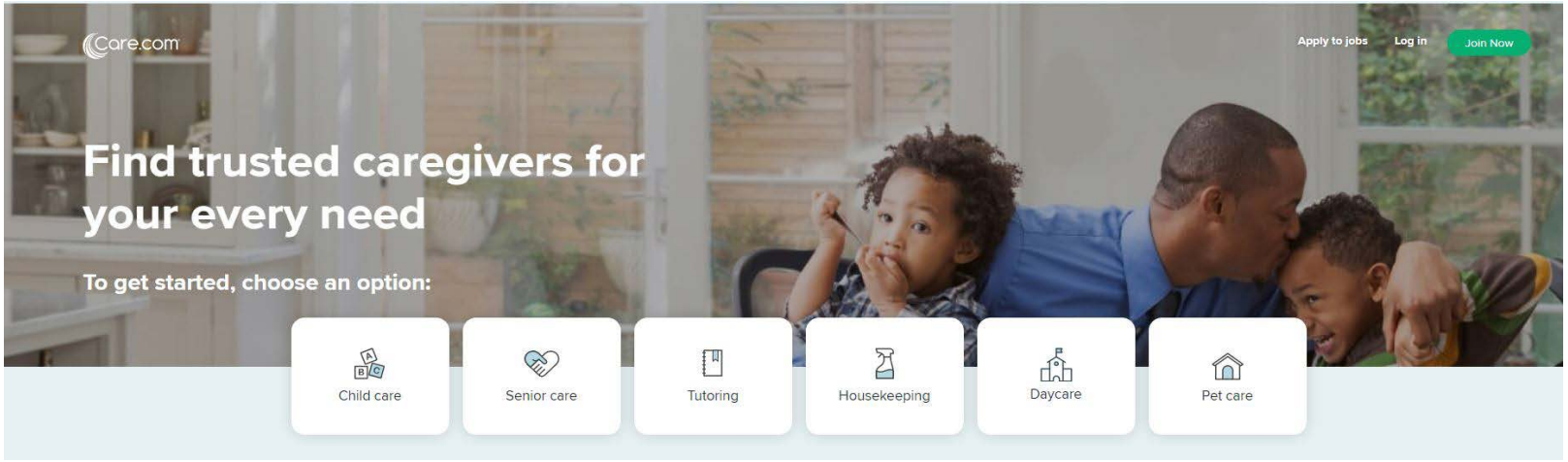
PLAN DESIGN: Care.com is an online caregiving platform that allows you to search, interview, and screen caregivers to find the right care for your needs. With a care.com membership, it makes finding a caregiver easy. Please note that while Robins & Morton will cover the cost of a premium membership, team members will remain responsible for the actual cost of care.

2025

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

SERVICES:

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



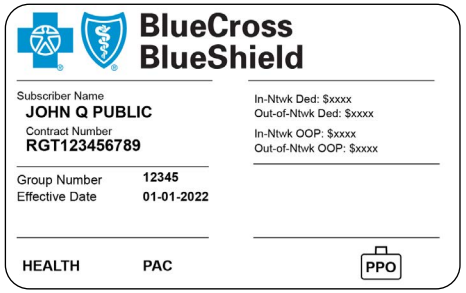
other

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 apps and cards to your mobile device.

IDENTIFICATION CARDS



ALABAMA BLUE

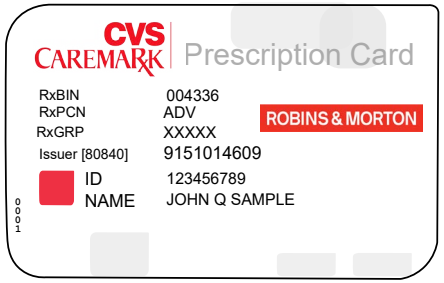
Blue Cross Blue Shield of Alabama administers the medical benefits for Robins & Morton. Present this card when you visit your doctor, hospitals, laboratories and others that provide you medical services. You can also access the mobile app for your card. Most providers will ask for your ID card with each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

GET IT ON Google Play

Download on the App Store

Website: http://www.bcbsal.org

Customer Service: 800.292.2262



CVS CAREMARK

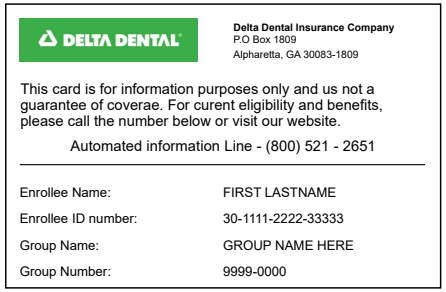
Your prescription drug benefits are provided by CVS/ Caremark. Present this card at your pharmacy to fill your prescriptions. In most cases, you will only need to present this card once to a pharmacy. You will receive this card upon enrollment in a medical plan.

GET IT ON Google Play

Download on the App Store

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.

GET IT ON Google Play | Download on the 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.

GET IT ON Google Play | Download on the App Store

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 LPFSA with contributions from your paycheck to pay for vision or dental expenses only.

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

GET IT ON Google Play | Download on the App Store

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.

GET IT ON Google Play | Download on the App Store

Website: https://www.vsp.com

Customer Service: 800.877.7195

Saver 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 2025 maximum contribution is **$4,300** for single coverage and **$8,550** 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 Disorders and Substance Abuse)

Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible For individual coverage, no benefits, except preventive care, are paid by the plan until medical expenses paid by the individual equal the deductible amount. For family coverage, no benefits, except preventive care, are paid by the plan to 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	**$3,300 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 Disorders 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 Disorders 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

Saver Plan continued

PHYSICIAN BENEFITS

(Includes Mental Health Disorders 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.

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.

PRESCRIPTION DRUG BENEFITS

Prescription Drugs	Prescription drug benefits are covered through CVS Caremark.

Saver Plan continued

BENEFITS FOR OTHER COVERED SERVICES

(Includes Mental Health Disorders 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
Assisted Reproductive Technology • Limited to $10,000 per individual per calendar year • Precertification required	Covered at 80% of the allowed amount, subject to calendar year deductible	Not covered

HEALTH MANAGEMENT BENEFITS

(Includes Mental Health Disorders and Substance Abuse)

Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231.
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and other specialized conditions.
Baby Yourself®	A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at AlabamaBlue.com/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.

Catastrophic 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 **$4,300** for single coverage and **$8,550** 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 Disorders 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 a family member until that individual family member meets the individual deductible amount or the total medical expenses paid by the family equal the family deductible amount	**$5,000 self-only coverage; $10,000 family coverage** Calendar year deductible amounts met in-network will not apply to the out-of-network calendar year deductible	**$10,000 self-only coverage; $20,000 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	**$6,000 self-only coverage; $12,000 family coverage** After you reach your self-only 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 Disorders 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 70% of the allowed amount, subject to calendar year deductible	Covered at 50% 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 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible

OUTPATIENT HOSPITAL BENEFITS

(Includes Mental Health Disorders 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 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Emergency Room (Medical Emergency)	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible **Mental Health Disorders and Substance Abuse Services** covered at 70% of the allowed amount, subject to in-network calendar year deductible
Emergency Room (Accident)	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 70% 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 70% of the allowed amount, subject to calendar year deductible	Covered at 50% 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 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible

Catastrophic Plan continued

PHYSICIAN BENEFITS

(Includes Mental Health Disorders 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 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Second Surgical Opinions	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Surgery & Anesthesia	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Maternity Care	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Chemotherapy, Diagnostic Lab, Dialysis, IV Therapy, Pathology, Radiation Therapy & X-ray	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Applied Behavioral Analysis (ABA) Therapy	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% 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 subject to calendar year 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
Additional Preventive Services 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
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
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

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.

PRESCRIPTION DRUG BENEFITS

Prescription Drugs	Prescription drug benefits are covered through CVS Caremark.

BENEFITS FOR OTHER COVERED SERVICES
(Includes Mental Health Disorders 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 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Ambulance Service	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 70% of the allowed amount, subject to calendar year deductible
Participating Chiropractic Services Limited to 20 visits per member per calendar year	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Durable Medical Equipment (DME)	Covered at 70% of the allowed amount, subject to calendar year deductible	Covered at 50% 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 70% of the allowed amount, subject to calendar year deductible	Covered at 50% 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 70% of the allowed amount, subject to calendar year deductible	Covered at 50% 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
Home Health and Hospice	Covered at 100% of the allowed amount, subject to calendar year deductible	Covered at 50% 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 70% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Assisted Reproductive Technology • Limited to $10,000 per individual per calendar year • Precertification required	Covered at 80% of the allowed amount, subject to calendar year deductible	Not covered

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

Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231.
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and other specialized conditions.
Baby Yourself®	A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at AlabamaBlue.com/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.
- Bariatric Surgery, Gastric Restrictive procedures and complications arising from these procedures are not covered under this plan. Please see your benefit booklet for more detail and for a complete listing of all plan exclusions.

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	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • $80 Walmart®/Costco® frame allowance	Included in Prescription Glasses	Every other calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every calendar year
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$0 $95–$105 $150–$175	Every calendar year
Contacts (Instead of glasses)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
Primary Eyecare	• As a VSP member, you can visit your VSP doctor for medical and urgent eyecare. Your VSP doctor can diagnose, treat, and monitor common eye conditions like pink eye, and more serious conditions like sudden vision loss, glaucoma, diabetic eye disease, and cataracts. Ask your VSP doctor for details.	$20	As needed

PROTEC SAFETY® (TEAM MEMBER-ONLY COVERAGE)

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Frame	Fully covered when you choose a safety frame from your VSP doctor's ProTec Eyewear® collection Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	$10 for frame and lenses	Every 24 months
Lenses	Prescription single vision, lined bifocal, and lined trifocal Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	Combined with frame	Every 12 months

EXTRA SAVINGS

Glasses	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	No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities

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)

YOUR RIGHTS, LEGAL NOTICES, AND DISCLAIMERS

ROBINS & MORTON DISCLAIMER

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

- The plan determines the amount it would have paid less than the primary plan's allowable expense
- If this plan would have paid less that the primary plan paid, this plan pays no benefits
- If this plan would have paid more than the primary plan paid, this plan will pay the difference
- The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

ELIGIBILITY DISCLAIMER

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

HIPAA SPECIAL ENROLLMENT NOTICE

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

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICES

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

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

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

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

NOTICE OF THE ROBINS & MORTON EMPLOYEE BENEFIT PLAN HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The effective date of this Notice of the Robins & Morton Employee Benefit Plan is October 1, 2024.

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

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

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

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

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

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

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

RECEIPT OF YOUR PHI BY THE COMPANY AND BUSINESS ASSOCIATES

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

Plan Sponsor: The Company is the Plan Sponsor and Plan Administrator. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the Company a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice.

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

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

Business Associates: The Plan and the Company hire third parties, such as a third-party administrator (the "Claims Administrator"), to help the Plan provide health benefits. These third parties are known as the Plan's "Business Associates." The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or

the Company to assist or carry out the terms of the Plan. In addition, these Business Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and the Company must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure and will require their subcontractors and agents to do so, too.

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

HOW THE PLAN MAY USE OR DISCLOSE YOUR PHI

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

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

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

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

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

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

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

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

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

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

- Quality assessment and improvement activities
- Disease management, case management and care coordination
- Activities designed to improve health or reduce health care costs
- Contacting health care providers and patients with information about treatment alternatives
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.
- The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.
- Underwriting (with the exception of PHI that is genetic information) premium rating and performing related functions to create, renew or replace insurance related to the Plan
- Planning and development, such as cost-management analyses
- Conducting or arranging for medical review, legal services, and auditing functions
- Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

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

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

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

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

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

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

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

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

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

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

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

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

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

Authorization to Use or Disclose Your PHI

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

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

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

The Plan May Contact You

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

YOUR RIGHTS WITH RESPECT TO YOUR PHI

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

Request Restriction on Certain Uses and Disclosures: You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

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

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

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

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

Right to Amend: You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

Accounting: You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred more than six years before the date of your request, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice. Your request must state a time period which may not include dates more than six years before the date of your request. 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 Saver plan, there are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 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/hcpf/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.flmedicaidtplrecovery.com/flmedicaidtplrecovery.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: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

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.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@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: HHSHIPPProgram@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://dhcfp.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.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

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

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: 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/Services/Assistance/Pages/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://dhhr.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 employmentbased 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 employees. Eligible employees are:
  - Hourly employees
  - Salary employees

With respect to dependents:

We do offer coverage. Eligible dependents are:

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

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

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

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

NOTES

How to Enroll

hr.robinsmorton.net

During Open Enrollment

(October 26 - November 6, 2024)

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 6, 2024.

For New Hires

(30 days from date of hire)

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

✓ You have 30 days from your date of hire 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.

Need help? The HR Helpline is available to assist you.

(205) 803-0102

Monday–Thursday
8:00 a.m. to 4:00 p.m. CST
Friday
8:00 a.m. to 2:00 p.m. CST.

You can also submit your questions by emailing AskHR@robinsmorton.com

ROBINS & MORTON

400 Shades Creek Parkway
Birmingham, AL 35209

OPEN ENROLLMENT

OCTOBER 26–NOVEMBER 6, 2024

For detailed instructions on how to enroll, see page 50.