2024 Benefit Enrollment Guide

yourHealth, yourChoice

Employee Name:

Benefit Effective Date:

Enroll by Date:

Enroll at: www.benefitsolver.com

For Enrollment Instructions, Refer to Page 7

Para obtener información sobre la inscripción anual de plan de salud en español, comuníquese con su departamento local de Recursos Humanos / Beneficios.

Table of Contents

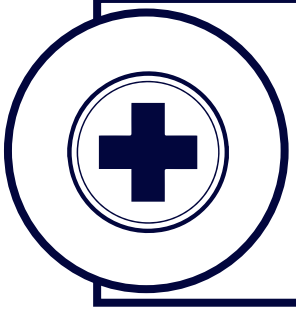
This guide is intended to provide a high-level overview and general information of your benefit options for 2024. For details about your benefits, refer to your summary plan descriptions (available through your Human Resources/Benefits Department and online at **www.benefitsolver.com**). We have made every effort to report the information in this guide accurately. This guide does not include all of the terms, coverage, exclusions, limitations and conditions of the plan document. However, if a discrepancy exists between this guide and the plan document, the plan document will govern. This guide does not imply a guarantee of employment or a continuation of benefits. CRH Americas reserves the right to suspend, change or amend these benefits at any time, for any reason for any active, inactive, retired, disabled or terminated employees.

For Union Members: If you are in a bargaining unit that is represented by a union, you may or may not be eligible for all or part of the CRH Americas health and welfare benefits. Your eligibility and participation in all or part of the CRH Americas plans is dependent on your specific union bargaining agreement.

CRH Americas is committed to providing our employees with a quality benefits package for you and your family to help you stay healthy, feel secure and maintain a good work/life balance. We encourage you to read and understand the options available so you can make the choice that is right for you and your family. This guide, along with other available resources will help you understand your options.

We thank you all for your hard work and your efforts to keep plan costs down by making good healthcare decisions. The healthy choices you make now contribute to lower healthcare costs in the future.

Benefits Overview



Healthcare Plans

CRH Americas is proud to offer a healthcare package for you and your family, which bundles the following plans under one premium:

- Medical (PPO and High Deductible)
- Pharmacy
- Employee Assistance Program (EAP)
- Dental
- Vision

Spending Accounts

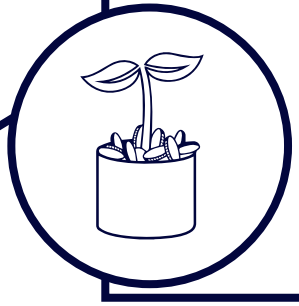
CRH Americas offers the below pre-tax spending accounts to assist you in paying for IRS qualified expenses:

- Health Savings Account (HSA)
- Healthcare Flexible Spending Account (HFSA)
- Dependent Day Care Flexible Spending Account

Life & Disability

CRH Americas offers protection for you and your family from potentially devastating financial losses due to sickness, injury or loss of life.

- Basic Life / AD&D (company paid)
- Voluntary Life / AD&D for employee, spouse, and dependent children under age 26
- Short-Term & Long-Term Disability (company paid)
- Paternity Leave - Paid leave for a life event for a birth, adoption, or placements of a child.



401(k)

CRH Americas offers the opportunity for you to set money aside for your future by contributing to a retirement account.

- Traditional Pre-Tax
- Roth Post-Tax

The company provides an employer match contribution up to 5%.

Vendor Contact Information

You may contact any of the CRH Americas benefit providers regarding specific plan questions. Many of the websites provide excellent information and tools regarding your benefits.

Enrollment & Eligibility

888.437.4866
www.benefitsolver.com

- Benefit enrollment assistance
- Verification of eligibility and coverage
- Benefit plan coverage and election
- COBRA support or questions
- Questions on MyChoice accounts:
  - Flexible Spending Account (FSA)
  - Dependent Day Care Account (DCFSA)
  - Health Savings Account (HSA)

Medical Claims

800.826.9781
www.umr.com

- Combined Medical & Prescription ID cards
- Find a medical care provider
- Pre-certification/pre-authorization
- Coordination of benefits
- Medical claims details
- EOB statement (Explanation of Benefits)
- Assistance with medical claims issues

Prescription Drug Claims

800.378.0458
www.caremark.com

- Combined with medical card
- Find a pharmacy
- Prescription drug formulary
- Information on retail 90-day refills
- Home delivery (mail order)
- Rx history
- Specialty drugs:

CVS Specialty
866.846.3095
www.cvsspecialty.com

Dental Claims

800.521.2651
www.deltadentalins.com

- Dental ID cards
- Find a dental care provider
- Dental coverage details
- Dental claims status
- Assistance with dental claims issues

Vision Claims

866.723.0513
www.eyemedvisioncare.com

- Vision ID cards
- Find a vision care provider
- Vision coverage details
- Vision claims status
- Assistance with vision claims issues

Life/Disability/Leave Claims

866.215.1720
www.unum.com

- File a new leave of absence or disability claim
- Life and/or disability status
- Report intermittent hours of absence
- To request portability/convert paperwork: **866.220.8460**

Employee Assistance (EAP)

866.248.4096
www.liveandworkwell.com

- Confidential referral for various services:
  - Mental health
  - Legal services
  - ID recovery
  - Financial services
  - Tobacco cessation
- Face-to-face counseling

Teladoc

1.800.Teladoc
www.teladoc.com

- Virtual primary care and mental health
- 24/7 video visit with a doctor to discuss common health conditions
- Counseling services

Retirement – 401k

800.835.5095
www.401k.com

- View 401k account balance
- Update beneficiary information
- Elect or change deferral percentage
- Allocate investments elections
- Apply for 401k loan

Benefit Eligibility

Eligible Employees

Full-time non-union active employees of CRH Americas working and earning income in the U.S. (or union employees eligible to receive these benefits pursuant to a collective bargaining agreement) are eligible to participate in the company's benefit programs.

- An eligible employee must be classified as full-time and regularly scheduled to work an average of 30 hours per week.
- New hires become eligible on the first of the month following sixty (60) days of continuous employment.
- In order to meet the Affordable Care Act's Employer Mandate, CRH Americas will offer health insurance coverage in 2024 to hourly employees who may have been previously ineligible, if they worked an average of 30 hours per week during the 2023 measurement period.
- Eligible spouses/dependents who work for CRH Americas may enroll as a participant or be covered as an enrolled dependent (spouse or child) of the other, but not both.

If you are no longer eligible or leave CRH Americas, coverage of these plans will terminate the last day of the month in the month of classification change and/or termination.

Rehired Employees

- If the break in service is 30 days or less, coverage will be reinstated with the same elections and no lapse in coverage as if they had never terminated employment.
- If the break in service is 31 days to 180 days, employee is eligible for coverage effective 1st of day of the month following date of rehire. Employee must make an active election to gain coverage.
- If break in service is more than 180 days, New hire eligibility will apply and coverage would be effective 1st day of the month following sixty (60) days of employment. Employee must make an active election to gain coverage.
- If initial eligibility was not met and there is a break in service, the time from the initial hire date will count towards eligibility.

Your Eligible Dependents

- Your legal spouse
- Children, Stepchildren, Adopted Child, or any other child you support up to the end of the month of their 26th birthday, regardless of student status
- Dependents totally and permanently disabled before age 19 and subject to verification

NOTE: Domestic Partners and Common Law Marriage are NOT eligible and excluded under the plan.

Qualifying Life Event

The benefits you choose will remain in effect until December 31, 2024, as IRS rules do not allow benefit changes during the plan year unless you have a qualifying life event (change in family or employment status). **Qualifying Life Event and required documentation must be submitted in Benefitsolver within 60 days of the event date.**

Types of Qualifying Life Events Include:

- Change in marital status (marriage, divorce)
- Change in number of dependents (birth of child, adoption)
- Death (legal dependent)
- Change in employment that results in loss of benefits
- Loss of coverage
- Obtain other coverage
- HIPAA Special Enrollment, Court Judgment or Decree
- Medicare or Medicaid enrollment, or loss of coverage

Note: Newborns are covered for the first 30 days after birth, but are NOT automatically added to the plan. You must enroll newborns within 60 days of birth.

Changes in Elections

It is your responsibility to notify CRH Americas of any family life event as soon as possible and within the specified number of days. If notification is not made within 60 days, you will not be allowed to make a benefit change until the next Annual Open Enrollment due to IRS rules. You must go online at www.benefitsolver.com or call the CRH Americas Benefits Helpline at 888.437.4866 to make the change and provide the required documentation with proof of the event. Adding a dependent may require dependent verification. Dropping a dependent may result in a COBRA qualifying event. Additional documentation may be required.

Annual Open Enrollment

A period of time once a year held in the fall, in mid-October and November, that allows employees to add, waive, or make changes to their benefit elections for the upcoming plan year.

Dependent Verification Process and Guidance

Action required for employees to verify and add dependents to benefits

It is very **important** that you only enroll eligible dependents in the CRH Americas Healthcare Plan. **When you initially enroll in benefits as a New Hire or when you enroll a new dependent, including during Open Enrollment**, you will be asked to provide documentation to verify your dependent's eligibility. Failure to provide the appropriate documentation will result in your dependent not being covered on the CRH Americas Healthcare Plan.

You will receive a letter from Businessolver requesting verification of your dependent's eligibility. You must provide the required documentation. This letter is also available under your personal documents on **www.benefitsolver.com**. Examples of required documentation include the following:

Spouse

» Photocopy of an official Marriage Certificate.

Child

» Photocopy of Birth Certificate or Hospital Birth record (hospital birth record that shows your name or the name of your enrolled spouse as the parent of the child and is signed by a hospital administrator or physician on staff).

» Adoption Certificate or Court Assignment of Guardianship that is signed and/or stamped by a member of the court.

» If your spouse is not enrolled and his or her name is on the birth certificate or the hospital birth record and your name is not listed, you must also provide a copy of your marriage certificate to establish the relationship of the child to the employee.

» When adding a dependent be prepared with their SSN and Date of Birth.

Return the required documentation to:

Scan and Upload: Login to **www.benefitsolver.com** Documentation that is scanned and uploaded is processed more efficiently.

If you have forgotten your password, select the 'Forgot My Password' link. The company key is: OLDCASTLE.

Visit your personal message center located at the top of your home page.

View the 'Action Required Regarding Your Qualifying Life Event Change' message.

Scan and upload the required documentation to the message by selecting the upload document option.

Email: **dv@businessolver.com**

Fax: **877.769.8799**

CRH Americas
c/o Businessolver
P.O. Box 310552
Des Moines. IA 50331

TIMELY SUBMITTAL OF DOCUMENTS IS REQUIRED.

» *Do not mail original documents as they will not be returned.*

» *Verification MUST be returned by the due date or your dependents WILL NOT be covered.*

Dependent Social Security Number Request

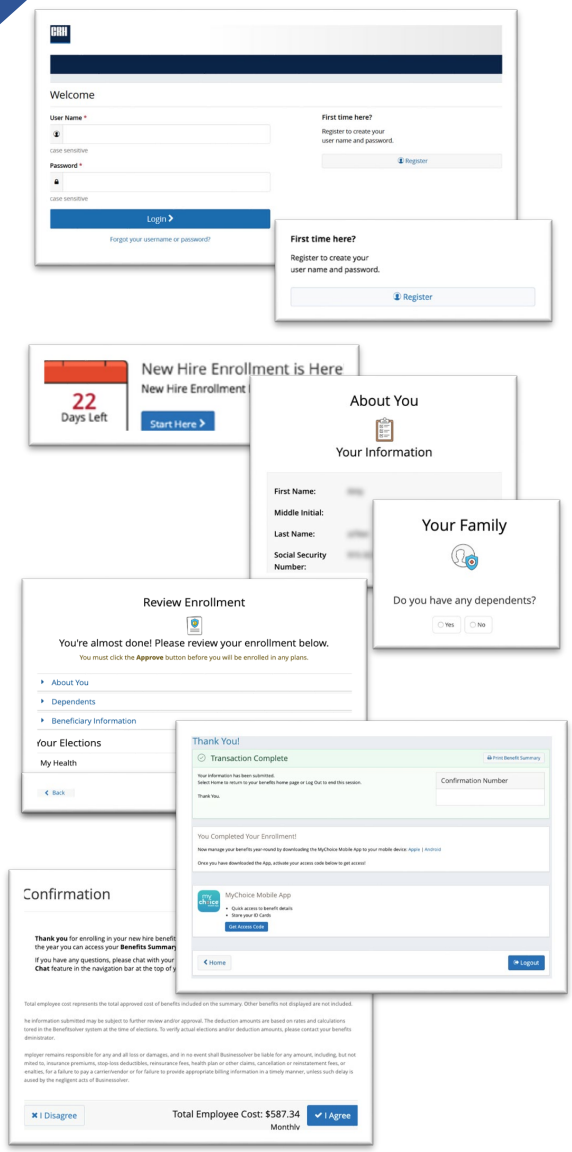
Request for Social Security Numbers Pursuant to PPACA Section 6055 for Coverage Year 2024

Pursuant to Section 6055 of the Patient Protection and Affordable Care Act, we are required to file an informational return with the IRS, which in part identifies the individuals to whom we provided Minimum Essential Coverage (MEC). This information will assist you and the IRS in establishing that all identified individuals have satisfied their obligations under the Individual Mandate to maintain MEC and are therefore not subject to a penalty.

Please review dependent information during the open enrollment process and provide any missing Social Security Numbers (SSNs) for currently covered dependents. You will be prompted to enter SSNs for any new dependents added during the open enrollment process.

Enroll in your Benefits

Action is required to enroll, change, or waive coverage



LOGIN Online

Visit **www.benefitsolver.com** and login using your username and password.

First time users: **Register** your username and password and answer a few security questions. The case-sensitive company key is **OLDCASTLE** Log in using your new username and password.

Click on the **Forgot your username or password?** link to reset your login details.

EXPLORE YOUR OPTIONS

Explore the site to learn about your benefits. You'll find lots of helpful information in the **Reference Center**.

The calendar at the top of the **Home** page lets you know how many days you must enroll.

START YOUR ENROLLMENT

Click the **Start Here** button to review your personal information and add or edit any dependents you wish to cover.

You will need to provide each dependent's legal name, Social Security Number, and birth date to add them to your coverage.*

*You will be required to provide documentation to prove your relationship to each dependent.

WAYS TO ENROLL IN COVERAGE

MyChoice Recommendation Engine

Answer a few simple questions to receive a personalized benefits recommendation. Your answers are never shared.

Explore on your own

Use the **Next** and **Back** buttons to review and elect options available to you. Choose or decline coverage for each option and select which family members you want to cover.

REVIEW AND FINALIZE YOUR ELECTIONS

Make sure your personal information, elections, dependents, and beneficiaries are accurate, then approve your elections.

To finish, click **I Agree**. When your enrollment is complete, you will receive a confirmation number and can print your **Benefit Summary** for your records.

SCAN & ENROLL

Enroll in your benefits from your mobile device. Visit **https://benefitsolver.com** or simply scan this QR code and tap your way through your elections.

Questions? 888-437-4866
Monday-Friday 7 a.m. – 7 p.m. CST
www.benefitsolver.com
Company Key: OLDCASTLE

GET THE MYCHOICE MOBILE APP

1. Visit **www.benefitsolver.com** and login using your username and password.
2. Click the **Get Access Code** button to text a link to your device to easily install the MyChoice Mobile App. Choose your device's operating system (iOS for Apple or Android), and type in your phone number with area code to text a link to download the Mobile App sent directly to your phone.
3. Use the 6-digit Access Code to activate the Mobile App on your device. Answer the security questions and provide multi-factor authentication.

FIRST-TIME USERS

Register your username and password and answer a few security questions. The case-sensitive company key is **OLDCASTLE**. Log in using your new username and password.

START YOUR ENROLLMENT

The **New Tasks** will alert you the enrollment opportunity is available. Tap that to begin.

Click the **Start Enrollment** button to enter and review your personal information and add or edit any dependents you wish to cover.

If you are adding dependent(s) to your coverage, you will need to provide each dependent's legal name, Social Security number, and birth date.*

**You will be required to provide documentation to prove your relationship to each dependent.*

2 WAYS TO ENROLL IN COVERAGE VIA THE APP

MyChoice Recommendation Engine

Answer a few simple questions to receive a personalized benefits recommendation. Your answers are never shared.

Explore on your own

Use the **Next** and **Back** buttons to review and elect options available to you. Review plan documents and use the **Compare** and **Plan Details** tools to view details and costs for the options available to you. Choose or decline coverage for each election and select which family members you want to cover.

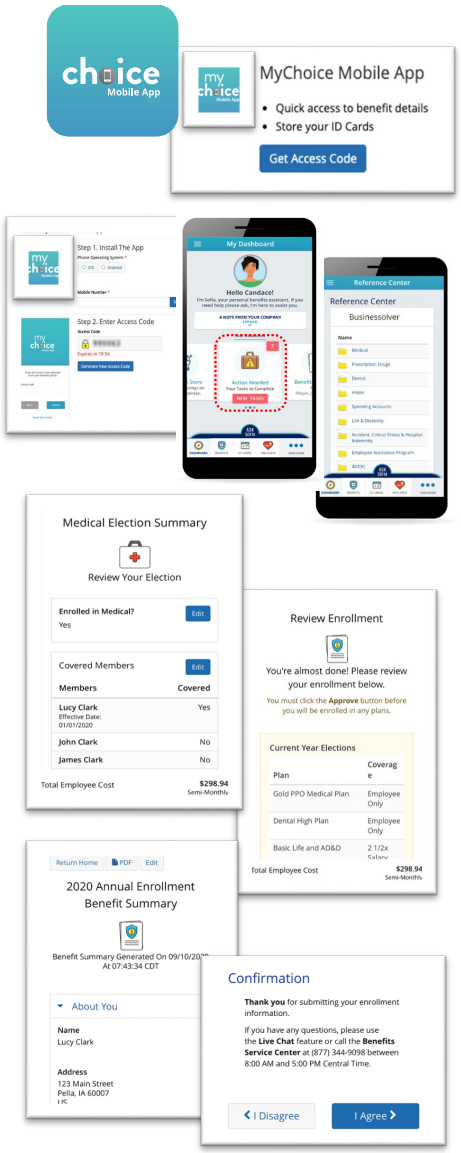
REVIEW AND FINALIZE YOUR ELECTIONS

Make sure your personal information, elections, dependents, and beneficiaries are accurate, then **Approve** your elections.

To finish, click **I Agree**. When your enrollment is complete, you will receive a confirmation number and can review your **Benefit Summary**.

AFTER YOU ENROLL

Return to the **Dashboard** to check for any additional tasks needed to complete your enrollment.



Questions? 888-437-4866
Monday-Friday 7 a.m. – 7 p.m.
www.benefitsolver.com
Company Key: OLDCASTLE

GET IT ON Google Play

Download on the App Store

*SSO Access Code Instructions: First, log in to your benefits portal account and click the **Get Access Code** button in the MyChoice Mobile App section of your home page. The page will open displaying an Access Code. Enter this code when prompted in the MyChoice Mobile App.

Glossary of Common Medical Terms

Allowed Amount
Maximum amount on which payment is based for covered healthcare services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference.

Coinsurance
Your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Copayment
A fixed amount (for example, $25) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.

Deductible
The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $800, your plan won't pay anything until you've met your $800 deductible for covered healthcare services subject to the deductible. The deductible may not apply to all services.

Formulary
A list of your covered prescription drugs. It includes generic, brand name and specialty drugs as well as preferred drugs that, when selected, can lower your out-of-pocket costs. The formulary is subject to change at any time.

In-Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide healthcare services.

Out-of-Network
The facilities, providers and suppliers your health insurer or plan has not contracted with to provide healthcare services.

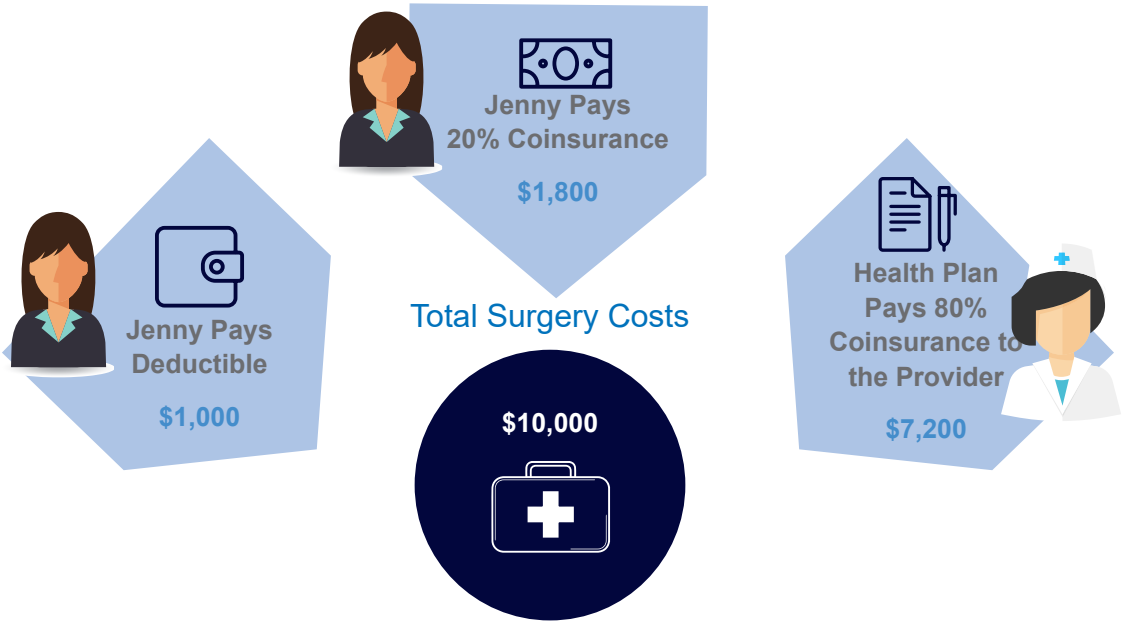
Out-of-Pocket Limit
The most you pay during a policy period, usually a year, before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges, penalties for noncompliance, and healthcare this plan doesn't cover.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of healthcare services for a patient.

Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

To see a real life example of some of the medical terms above, see below.
Jenny is on the PPO Medical Plan and is needing a surgery. Her surgery's total cost is $10,000.
Below is an explanation on how the plan would pay.

Out-of-Pocket Maximum: Jenny Paid $2,800 Of Her $6,000 Maximum



CRH Americas PPO & HDHP 2024 Benefit Summary

CRH's plan provides both in- and out-of-network benefits. In-network benefits are provided through the **Choice Plus Network** with UMR. By using a preferred provider, you are assured to receive the maximum benefits available. Find network providers using **Find a Doctor** at **UMR.com**.

CRH's medical choices of a PPO or HDHP with HSA give employees options regarding paying for benefits. The tables below show the amounts you are responsible for paying.

NOTE: Coinsurance is shown as Member Responsibility / Plan Responsibility.

Plan Provisions	PPO In-Network	PPO Out-of-Network	HDHP In-Network	HDHP Out-of-Network
Calendar Year Deductible*	$1,000 Individual / $3,000 Family	$2,000 Individual / $6,000 Family	$3,200 Individual / $6,400 Family	$6,400 Individual / $12,800 Family
Out-of-Pocket Maximum – per calendar year (includes the deductible, copays and coinsurance)	$6,000 Individual / $12,000 Family	Unlimited	$6,500 Individual / $13,000 Family	Unlimited
CRH Americas HSA Contribution	N/A		Employee: $500 | Employee +1: $750 Employee + 2 or more: $1,000 | Family: $1,000	
Lifetime Maximum per Participant	Unlimited		Unlimited	
Inpatient Hospital Services Penalty for Failure to Pre-certify	20% / 80% $250	40% / 60% $250	20% / 80% $250	40% / 60% $250
EMERGENCY ROOM/TREATMENT ROOM (Accident and Medical Emergency Situation within 48 hours)				
Facility Charges	Plan pays 80% after $150 member copay; deductible waived		20% / 80%	
Physician Charges			20% / 80%	
Urgent Care	$25 copay		20% / 80%	
NON-EMERGENCY SITUATIONS				
Facility Charges	20% / 80%	40% / 60%	20% / 80%	40% / 60%
Physician Charges	20% / 80%	40% / 60%	20% / 80%	40% / 60%
MEDICAL-SURGICAL SERVICES				
Office Visit	$25 PCP copay; $40 specialist copay	40% / 60%	20% / 80%	40% / 60%
Online Visit through Teladoc Health	$10 copay/doctor, therapist or psychologist	N/A	20% / 80%	N/A
Physician Surgical Services Inpatient	20% / 80%	40% / 60%	20% / 80%	40% / 60%
Physician Surgical Services Outpatient	20% / 80%	40% / 60%	20% / 80%	40% / 60%
Facility Surgical Services Outpatient	20% / 80%	40% / 60%	20% / 80%	40% / 60%
Home Infusion Therapy	20% / 80%	40% / 60%	20% / 80%	40% / 60%
In-Vitro Fertilization	Not Covered		Not Covered	

*If you are enrolled in the *family* option, your plan contains two (2) components: an *individual deductible* and a *family deductible.* Having two (2) components to the *deductible* allows each member of your *family* the opportunity to have your *Plan* cover medical expenses prior to the entire dollar amount of the *family deductible* being met. The individual *deductible* is embedded in the *family deductible.*

if you, your spouse, and child are on a *family* plan with a $3,000 *family* embedded *deductible,* and the *individual deductible* is $1,000, and your child *incurs* $1,000 in medical bills, his/her deductible is met, and your *Plan* will help pay subsequent medical bills for that child during the remainder of the *calendar year,* even though the *family deductible* of $3,000 has not been met yet.

CRH Americas PPO 2024 Benefit Summary (cont.)

Plan Provisions	PPO In-Network	PPO Out-of-Network	HDHP In-Network	HDHP Out-of-Network
Chiropractic Care in an Office Setting 20 visits per calendar year (combined in/ out-of-network)	$25 copay	40% / 60%	20% / 80%	40% / 60%
Physical, Occupational, and Speech Therapy 30 visits each per calendar year (combined in/ out-of-network) Pre-certification required after 18 visits	$25 copay	40% / 60%	20% / 80%	40% / 60%
DIAGNOSTIC X-RAY AND LABORATORY SERVICES				
Office	$25 PCP copay; $40 specialist copay	40% / 60%	20% / 80%	40% / 60%
Outpatient	20% / 80%	40% / 60%	20% / 80%	40% / 60%
Independent Lab or X-ray	20% / 80%	40% / 60%	20% / 80%	40% / 60%
PREVENTIVE CARE				
Routine Physicals/ Well Baby Care/ Mammograms/ Colorectal/Bone Density/PSA/Pap Smear/Cholesterol	0% / 100%*	Not Covered	0% / 100%*	Not Covered
OB/GYN and Immunizations	0% / 100%*	40% / 60%	0% / 100%*	40% / 60%
EXTENDED CARE SERVICES				
Home Healthcare 120 Visits Per Calendar Year	20% / 80%	40% / 60%	20% / 80%	40% / 60%
Skilled Nursing Facility 120 Days Maximum Per Calendar Year	20% / 80%	40% / 60%	20% / 80%	40% / 60%
Hospice Care Benefits used In-Network or Out-of-Network apply towards satisfying both maximums.	20% / 80%	40% / 60%	20% / 80%	40% / 60%

*Deductible Waived

Plan Provisions	PPO In-Network	PPO Out-of-Network	HDHP In-Network	HDHP Out-of-Network
MENTAL HEALTH (MH)/CHEMICAL DEPENDENCY				
Inpatient Services				
Hospital Services (Facility)	20% / 80%	40% / 60%	20% / 80%	40% / 60%
Physician Services	20% / 80%	40% / 60%	20% / 80%	40% / 60%
Outpatient Services				
Services Performed in Physician Office (Non-Surgical)	$25 copay	40% / 60%	20% / 80%	40% / 60%
Emergency Room/ Treatment Room/Facility Charges	100% after $150 copay	100% after $150 copay	20% / 80%	40% / 60%
Professional Provider	20% / 80%	40% / 60%	20% / 80%	40% / 60%

Plan Provisions	PPO	HDHP		
PRESCRIPTION DRUGS				
		Minimum	**Member % Coinsurance**	**Maximum**
Rx Out-of-Pocket Maximum per Calendar Year	$3,450 Individual / $6,900 Family per calendar year	N/A		
Retail				
Generic	$10 copay	$5	N/A	$5
Preferred Brand	$35 copay	$15	25%	$50
Non-Preferred Brand	$70 copay	$30	50%	$125
Specialty	30% coinsurance	N/A		
Mail-Order / 90-Day Retail				
Generic	$25 copay	$10	N/A	$10
Preferred Brand	$87.50 copay	$30	25%	$100
Non-Preferred Brand	$175 copay	$60	50%	$250

*Deductible waived

Pre-certification / Pre-authorization

Procedures requiring pre-certification include (but are not limited to) inpatient stays, inpatient and outpatient surgeries, durable medical equipment, transplants, outpatient advanced imaging. A complete list will be available at **www.umr.com** and **www.benefitsolver.com**.

Which plan is best for you?

CRH is proud to offer two comprehensive plan options, made to fit your needs. The high deductible health plan (HDHP) is designed to provide you with the lowest premium, but higher out of pocket costs. The PPO plan includes a higher premium, but lower out of pocket costs.

Employee Only Coverage Example

Below you will see examples of hypothetical individuals and how the plan components compared. For each service type, you will see some assumptions about the frequency and cost on the left-hand side of the chart.

Comparing Expected Costs

	LOW UTILIZER		MEDIUM UTILIZER		HIGH UTILIZER	
Cost of Covered Services (Quantity of Services and Estimated Costs)	**CRH PPO**	**CRH HDHP**	**CRH PPO**	**CRH HDHP**	**CRH PPO**	**CRH HDHP**
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
[1] Preventive Care Visit - $160	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)
[1] Primary Care Visit - $175	$25 Copay	$175 (Applied to Ded)	$25 Copay	$175 (Applied to Ded)	$25 Copay	$175 (Applied to Ded)
[1] Specialist Visit - $250	Did Not Utilize This Service		Did Not Utilize This Service		$40 Copay	$250 (Applied to Ded)
[1] Outpatient Procedure - $1,000	Did Not Utilize This Service		$1,000 (Applied to Ded)	$1,000 (Applied to Ded)	$1,000 (Applied to Ded)	$1,000 (Applied to Ded)
[1] Inpatient Surgery - $8,000	Did Not Utilize This Service		Did Not Utilize This Service		$1,600 (20% Coinsurance)	$3,020 ($1,775 Applied to Ded +$1,245 Coinsurance)
[1] Generic Rx - 10-day Supply - $17	$10 Copay	$17 (Applied to Ded)	$10 Copay	$17 (Applied to Ded)	$10 Copay	$5 Copay
[1] Non Preferred Rx - Monthly Cost- $100	Did Not Utilize This Service		$840 ($70 copay x 12 months)	$1,200 ($100 x 12 months)	$840 ($70 copay x 12 months)	$600 (50% coinsurance x 12 months)
Cost of Covered Services (Payments you make directly to providers)	**$35**	**$192**	**$1,875**	**$2,392**	**$3,515**	**$5,050**
+						
Annual Payroll Contribution (Enrolled in Employee Only Coverage, Standard Rate)	**$2,040 ($170 per month)**	**$1,128 ($94 per month)**	**$2,040 ($170 per month)**	**$1,128 ($94 per month)**	**$2,040 ($170 per month)**	**$1,128 ($94 per month)**
=						
Cost of Covered Services	$35	$192	$1,875	$2,392	$3,515	$5,050
Annual Payroll Contribution	$2,040	$1,128	$2,040	$1,128	$2,040	$1,128
- CRH Americas Contribution to HSA	N/A	-$500	N/A	-$500	N/A	-$500
= Total Employee Annual Cost	**$2,075**	**$820**	**$3,915**	**$3,020**	**$5,555**	**$5,678**

Employee + Spouse Coverage Example

Below you will see examples of hypothetical individuals and how the plan components compared. For each service type, you will see some assumptions about the frequency and cost on the left-hand side of the chart.

Comparing Expected Costs

	LOW UTILIZER		MEDIUM UTILIZER		HIGH UTILIZER	
Cost of Covered Services (Quantity of Services and Estimated Costs)	**CRH PPO**	**CRH HDHP**	**CRH PPO**	**CRH HDHP**	**CRH PPO**	**CRH HDHP**
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
[2] Preventive Care Visits - $160 Each	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)
[2] Primary Care Visits - $175 Each (Employee and Spouse)	$50 ($25 Copay x 2)	$350 (Applied to Ded)	$50 ($25 Copay x 2)	$350 (Applied to Ded)	$50 ($25 Copay x 2)	$350 (Applied to Ded)
[2] Urgent Care Visits - $225 Each (Spouse)	$50 ($25 Copay x 2)	$450 (Applied to Ded)	$50 ($25 Copay x 2)	$450 (Applied to Ded)	$50 ($25 Copay x 2)	$450 (Applied to Ded)
[1] Specialist Visit - $250 (Spouse)	Did Not Utilize This Service		$40 Copay	$250 (Applied to Ded)	$40 Copay	$250 (Applied to Ded)
[1] Outpatient Procedure - $1,000 (Spouse)	Did Not Utilize This Service		$1,000 (Applied to Ded)	$1,000 (Applied to Ded)	$1,000 (Applied to Ded)	$1,000 (Applied to Ded)
[1] Inpatient Surgery - $8,000 (Employee)	Did Not Utilize This Service		Did Not Utilize This Service		$2,400 ($1,000 Ded + $1,400 Coinsurance)	$4,020 ($3,025 Ded + $995 Coinsurance)
[2] Generic Rx - 10-day Supply - $17 (Employee and Spouse)	$20 ($10 Copay x 2)	$34 (Applied to Ded)	$20 ($10 Copay x 2)	$34 (Applied to Ded)	$20 ($10 Copay x 2)	$22 ($5 Copay + $17)
[1] Non Preferred Rx - Monthly Cost- $100 (Spouse)	Did Not Utilize This Service		$840 ($70 copay x 12 months)	$1,200 ($100 x 12 months)	$840 ($70 copay x 12 months)	$1,200 ($100 x 12 months)
Cost of Covered Services (Payments you make directly to providers)	**$120**	**$834**	**$2,000**	**$3,284**	**$4,400**	**$7,292**
+						
Annual Payroll Contribution (Enrolled in Employee + Spouse Coverage, Standard Rate)	**$4,200** ($350 per month)	**$2,220** ($185 per month)	**$4,200** ($350 per month)	**$2,220** ($185 per month)	**$4,200** ($350 per month)	**$2,220** ($185 per month)
=						
Cost of Covered Services	$120	$834	$2,000	$3,284	$4,400	$7,292
Annual Payroll Contribution	$4,200	$2,220	$4,200	$2,220	$4,200	$2,220
- CRH Americas Contribution to HSA	N/A	-$750	N/A	-$750	N/A	-$750
= Total Employee Annual Cost	**$4,320**	**$2,304**	**$6,200**	**$4,754**	**$8,600**	**$8,762**

Employee + Children Coverage Example

Below you will see examples of hypothetical individuals and how the plan components compared. For each service type, you will see some assumptions about the frequency and cost on the left-hand side of the chart.

Comparing Expected Costs

	LOW UTILIZER		MEDIUM UTILIZER		HIGH UTILIZER	
Cost of Covered Services (Quantity of Services and Estimated Costs)	**CRH PPO**	**CRH HDHP**	**CRH PPO**	**CRH HDHP**	**CRH PPO**	**CRH HDHP**
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
[2] Preventive Care Visits - $160 Each	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)
[2] Primary Care Visits - $175 Each (Employee and Child)	$50 ($25 Copay x 2)	$350 (Applied to Ded)	$50 ($25 Copay x 2)	$350 (Applied to Ded)	$50 ($25 Copay x 2)	$350 (Applied to Ded)
[2] Urgent Care Visits - $225 Each (Child)	$50 ($25 Copay x 2)	$450 (Applied to Ded)	$50 ($25 Copay x 2)	$450 (Applied to Ded)	$50 ($25 Copay x 2)	$450 (Applied to Ded)
[1] Specialist Visit - $250 (Child)	Did Not Utilize This Service		$40 Copay	$250 (Applied to Ded)	$40 Copay	$250 (Applied to Ded)
[1] Outpatient Procedure - $1,000 (Child)	Did Not Utilize This Service		$1,000 (Applied to Ded)	$1,000 (Applied to Ded)	$1,000 (Applied to Ded)	$1,000 (Applied to Ded)
[1] Inpatient Surgery - $8,000 (Employee)	Did Not Utilize This Service		Did Not Utilize This Service		$2,400 ($1,000 Ded + $1,400 Coinsurance)	$4,020 ($3,025 Ded + $995 Coinsurance)
[2] Generic Rx - 10-day Supply - $17 (Employee and Child)	$20 ($10 Copay x 2)	$34 (Applied to Ded)	$20 ($10 Copay x 2)	$34 (Applied to Ded)	$20 ($10 Copay x 2)	$22 ($5 Copay + $17)
[1] Non Preferred Rx - Monthly Cost-$100 (Employee)	Did Not Utilize This Service		$840 ($70 copay x 12 months)	$1,200 ($100 x 12 months)	$840 ($70 copay x 12 months)	$1,200 ($100 x 12 months)
Cost of Covered Services (Payments you make directly to providers)	**$120**	**$834**	**$2,000**	**$3,284**	**$4,400**	**$7,292**
+						
Annual Payroll Contribution (Enrolled in Employee + Child Coverage, Standard Rate)	**$3,660** ($305 per month)	**$1,944** ($162 per month)	**$3,660** ($305 per month)	**$1,944** ($162 per month)	**$3,660** ($305 per month)	**$1,944** ($162 per month)
=						
Cost of Covered Services	$120	$834	$2,000	$3,284	$4,400	$7,292
Annual Payroll Contribution	$3,660	$1,944	$3,660	$1,944	$3,660	$1,944
- CRH Americas Contribution to HSA	N/A	-$1,000	N/A	-$1,000	N/A	-$1,000
= Total Employee Annual Cost	**$3,780**	**$1,778**	**$5,660**	**$4,228**	**$8,060**	**$8,236**

Family Coverage Example

Below you will see examples of hypothetical individuals and how the plan components compared. For each service type, you will see some assumptions about the frequency and cost on the left-hand side of the chart.

Comparing Expected Costs

	LOW UTILIZER		MEDIUM UTILIZER		HIGH UTILIZER	
Cost of Covered Services (Quantity of Services and Estimated Costs)	**CRH PPO**	**CRH HDHP**	**CRH PPO**	**CRH HDHP**	**CRH PPO**	**CRH HDHP**
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
[2] Preventive Care Visits - $160 Each (Child)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)
[3] Primary Care Visits - $175 Each (Family)	$75 ($25 Copay x 3)	$525 (Applied to Ded)	$75 ($25 Copay x 3)	$525 (Applied to Ded)	$75 ($25 Copay x 3)	$525 (Applied to Ded)
[2] Urgent Care Visits - $225 Each (Child)	$50 ($25 Copay x 2)	$450 (Applied to Ded)	$50 ($25 Copay x 2)	$450 (Applied to Ded)	$50 ($25 Copay x 2)	$450 (Applied to Ded)
[1] Specialist Visit - $250 (Child)	Did Not Utilize This Service		$40 Copay	$250 (Applied to Ded)	$40 Copay	$250 (Applied to Ded)
[1] Outpatient Procedure - $1,000 (Child)	Did Not Utilize This Service		$1,000 (Applied to Ded)	$1,000 (Applied to Ded)	$1,000 (Applied to Ded)	$1,000 (Applied to Ded)
[1] Inpatient Surgery - $8,000 (Spouse)	Did Not Utilize This Service		Did Not Utilize This Service		$2,400 ($1,000 Ded + $1,400 Coinsurance)	$4,020 ($3,025 Ded + $995 Coinsurance)
[2] Generic Rx - 10-day Supply - $17 (Spouse and Child)	$20 ($10 Copay x 2)	$34 (Applied to Ded)	$20 ($10 Copay x 2)	$34 (Applied to Ded)	$20 ($10 Copay x 2)	$22 ($5 Copay + $17)
[1] Non Preferred Rx - Monthly Cost-$100 (Spouse)	Did Not Utilize This Service		$840 ($70 copay x 12 months)	$1,200 ($100 x 12 months)	$840 ($70 copay x 12 months)	$600 (50% coinsurance x 12 months)
Cost of Covered Services (Payments you make directly to providers)	**$145**	**$1,009**	**$2,025**	**$3,459**	**$4,425**	**$6,867**
+						
Annual Payroll Contribution (Enrolled in Family Coverage, Standard Rate)	**$5,880** ($490 per month)	**$2,940** ($245 per month)	**$5,880** ($490 per month)	**$2,940** ($245 per month)	**$5,880** ($490 per month)	**$2,940** ($245 per month)
=						
Cost of Covered Services	$145	$1,009	$2,025	$3,393	$4,425	$6,867
Annual Payroll Contribution	$5,880	$2,940	$5,880	$2,940	$5,880	$2,940
- CRH Americas Contribution to HSA	N/A	-$1,000	N/A	-$1,000	N/A	-$1,000
= Total Employee Annual Cost	**$6,025**	**$2,949**	**$7,905**	**$5,399**	**$10,305**	**$8,807**

UMR Resources

How to create a UMR Account

- Visit **umr.com**
- Select the Log in/Register button
- Ensure you have your ID card handy and follow the steps to get started

Make UMR.com Your First Stop

At **umr.com**, you will find everything you want to know-and need to do as soon as you login.

- Check your benefits & see what's covered
- Look up what you owe and how much you've paid
- Find a doctor in your network
- Review your EOB's
- Learn about medical conditions & your treatment options
- Access tools and trusted resources to help you live a healthier life

UMR Mobile App

With just a tap, you can:

- Access your digital ID card
- View your plan details on-demand-anytime, anywhere
- Find out if there is a co-pay for your upcoming appointment
- Chat, call or message UMR's member support team

Visit the app store to get started!

NurseLine

UMR's NurseLine service will connect you to a team of registered nurses who can answer your questions and provide advice. Nurses are on standby to help any time of day, seven days a week.

- Call NurseLine **877.950.5083**
- Chat live online
  - Log in to **umr.com**
  - Select Health center from myMenu
  - Look for the link in the "I need to.." section

Healthy You

UMR's award-winning digital health and wellness magazine, Healthy You, is available quarterly to view online, download and share. UMR's digital magazine features new and informative health and wellness articles and practical tools that support and encourage you to make healthy choices. You can access new and past issues by clicking the Healthy You magazine shortcut tile from the main home page on umr.com.

CARE Programs

UMR CARE

Through UMR CARE, you have access to a staff of experienced, caring nurses who help you get the most out of your health plan benefits. They work with you, your doctors and other medical advisors to get the services that best meet your needs.Some examples of when UMR CARE can help you:

- Maternity
- Post Partum
- High ER Utilization
- Medical Specialty Drugs
- High-Risk Health Conditions

Maternity CARE

- Whether you are considering having a baby or are already expecting, UMR Maternity CARE can explain how to reduce your risks of complications and prepare you to have a successful, full-term pregnancy and a healthy baby.

Emerging CARE

- Assistance, advocacy and support to help avoid high risk health conditions

All CARE Programs can be accessed via **umr.com**.

Find the Right Provider

Where to Get Care When You Need it?

Choose from quality doctors and hospitals that are part of your plan. Login to **www.umr.com** to search for a provider in your plan. Select the UnitedHealthcare Choice Plus Network when searching for a provider.

Search for a provider under the following categories:

- Primary Care
- Urgent Care
- Behavior Health
- Lab (Blood Work)
- Imaging (MRI or X-ray)

Ask questions before you get medical care. Make sure every person and every facility involved is contracted in your elected network. Although out-of-network providers are under no obligation to charge within the In-Network Rate, consider negotiating the price before you receive the service to avoid being balance billed.

What should you do when you need care right away, but it's not an emergency?

The emergency room (ER) might be your first choice, but it is not always the best choice. You may end up in the waiting room for hours and pay more for care. You may have options that cost less and are quicker than the ER. Learn more about these options below and how to find care.

First call your primary care doctor

If it's not a true emergency, try calling your primary care doctor to make an appointment. Your doctor may tell you where to get immediate care or give you advice on the phone. If calling your primary care doctor isn't possible, you have other choices.

Urgent care center

For an illness or injury outside of regular clinic hours that requires attention right away but does not pose an immediate, serious threat to your health or life, you may want to visit an urgent care center. Urgent care centers have doctors who treat conditions that should be looked at right away but aren't as severe as emergencies, and they can often do X-rays, lab tests and stitches.

Emergency Room

If you think you are having a real emergency, or if you think you could put your health at serious risk by delaying care, call 911 or go to the nearest emergency room (ER). Life-threatening conditions such as severe shortness of breath, cuts and wounds that won't stop bleeding, sudden or unexplained loss of consciousness, chest pain, high fever accompanied by stiff neck, and coughing up or vomiting blood are all examples of medical emergencies that would warrant a visit to the ER.

These clinics are staffed by healthcare experts who give basic healthcare services to walk-in patients. Retail health clinics are usually found in a major pharmacy or retail store.

Walk-in doctor's office

A walk-in doctor's office typically doesn't require you to be an existing patient or have an appointment. They can handle routine care and treat common illnesses.

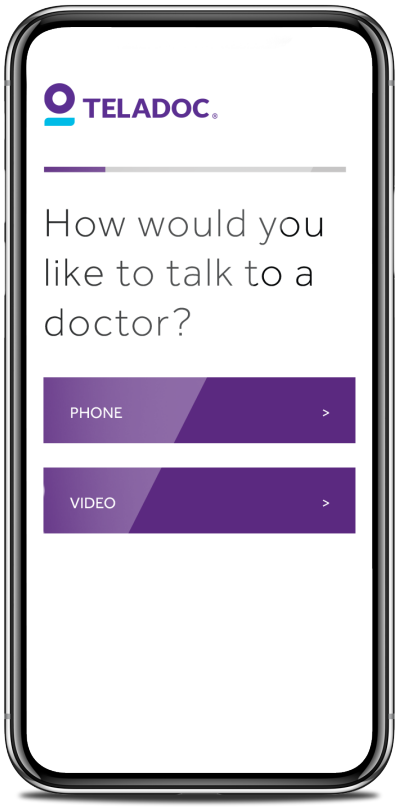
Teladoc

Teladoc Health can help you skip the trip to the ER or urgent care for non-emergency problems, avoid long wait times and save money since you can see a clinician within minutes by phone or video.Teladoc Health is here to listen, answer your questions and help you feel better faster.

Teladoc HEALTH

Set up your Teladoc Health account

in 4 easy steps



Download the app to talk to a doctor anytime, anywhere* by phone or video.

1 **Download the app**
Search for "Teladoc Health" in the App Store or on Google Play.

2 **Set up your account**
Once you've downloaded the app, select "Set up your account."

3 **Enter basic contact information**
Provide some information about yourself to confirm your eligibility. We'll confirm we found your benefits and you'll continue creating your account.

4 **Create your account**
Enter your address and phone number, create a username and password, pick security questions, and agree to terms and conditions.

*Teladoc Health is not available internationally.

Download the app to talk to a doctor

Visit TeladocHealth.com

Call 1-800-835-2362 | Download the app

10E-177-1_415798056_11112019

Group ID:

Regenexx®

CRH covers Regenexx under your health plan

PPO Plan: You will pay the specialist copay for office visits and consultations; all other services are subject to the deductible and applicable coinsurance.

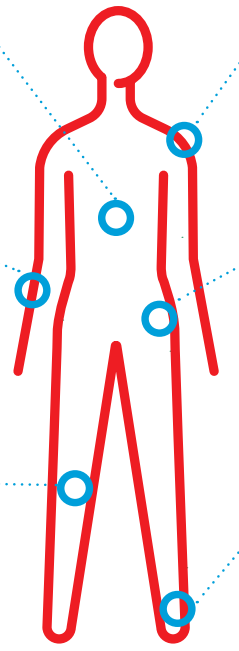
HDHP: All services are subject to the deductible before coinsurance will be applied.

Out of Pocket Maximum: This also applies on a calendar year basis and includes deductibles, copays and coinsurance.

Pre-Certification is NOT required for these procedures.

Regenexx uses your body's natural healing agents to replace the need for up to 70% of elective orthopedic surgeries. Your stem cells and blood platelets are concentrated in our on-site orthobiologics lab and injected under image guidance into the precise area of your injury. With Regenexx, you can get back to doing what you love without invasive surgery and lengthy recovery.

Conditions Treated



Spine
- bulging, collapsed, or herniated disc
- ruptured or torn disc
- degenerative disc disease
- disc extrusion
- disc protrusion
- back or neck nerve pain

Hand/Wrist/Elbow
- arthritis
- tennis elbow
- ulnar nerve entrapment
- CMC joint arthritis (thumb)
- carpal tunnel
- trigger finger

Knee
- arthritis
- meniscus tear
- sprain or tear of ACL/PCL
- sprain or tear of the MCL/LCL
- tendinopathy
- joint replacement alternative

Shoulder
- arthritis
- rotator cuff tears
- labral tear
- rotator cuff tendinosis
- joint replacement alternative

Hip
- osteonecrosis
- bursitis
- labral/labrum tear
- tendinopathy
- joint replacement alternative
- arthritis

Ankle/Foot
- arthritis
- instability
- bunions
- ligament sprain or tear
- plantar fasciitis
- achilles tendinopathy

Next Steps

To speak with a CRH Regenexx Patient Liaison,
call us at **866-385-4959** or visit **regenexxbenefits.com/crh**
to learn more about Regenexx and how we can help you avoid surgery

UNDERSTAND YOUR REGENEXX BENEFIT

A NEW APPROACH IN ORTHOPEDIC CARE

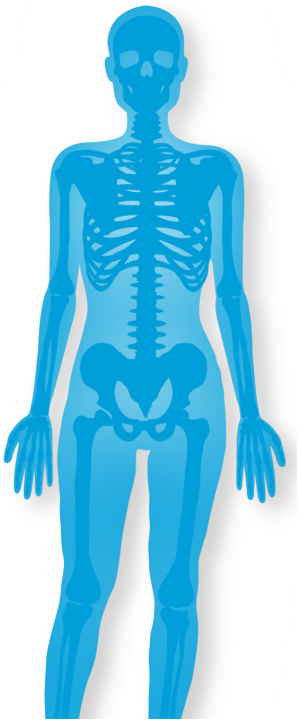
Regenexx is the founder and world-wide leader in Interventional Orthopedics, a new medical specialty that focuses on treating orthopedic injuries non-surgically. We harness a patient's own healing cells including blood platelets and stem cells to repair many common orthopedic injuries. We can treat most partial tears to muscle, tendons, and ligaments as well as degeneration of bone, cartilage, and discs in the spine.

CRH COVERAGE FOR REGENEXX

Regenexx is covered as an in-network benefit within the CRH health plans. In-network benefits for specialist services within your plan and in-network co-pay, deductible, and out-of-pocket coverage apply for all Regenexx services. Non-Regenexx services may fall under a different benefit level, and may or may not be treated as in-network.

ARE YOU A CANDIDATE?

Regenexx can diagnose and treat a broad range of orthopedic injuries without the need for invasive surgeries. Our experienced physicians use a variety of comprehensive approaches including regenerative medicine to repair damage to bones, muscles, cartilage, tendons, and ligaments non-surgically. We help patients avoid up to 70 percent of elective orthopedic surgeries.



Our education center can provide you with more detailed information about your benefit, help you find the location of the nearest Regenexx outpatient clinic, and offer an initial review of whether your condition may be treatable by Regenexx.

Call us today at **866-385-4959** or visit **regenexxbenefits.com/crh** to take the next step toward a healthier and more productive life.

CALL A REGENEXX PATIENT LIAISON AT 866-385-4959

LEARN MORE

Find out if a Regenexx procedure is right for you. At one of our 30-minute webinars, you'll learn:

1. The type of conditions Regenexx can treat.
2. How the Regenexx difference is based on research and outcomes.
3. What you can expect when undergoing a Regenexx procedure.
4. You'll also have an opportunity to learn how your specific benefit works.

To take the next step and sign up for a webinar, scan the QR code below to register, or visit:

regenexxbenefits.com/webinar?mailer

Employee Assistance Program (EAP)

When you have a long list of stressors — and a longer list of to-dos

Emotional Wellbeing Solutions is available 24/7 at no cost to you

Emotional Wellbeing

Emotional Wellbeing Specialists are available by phone to provide help with a range of life concerns and stressors, including:

- Relationship problems
- Workplace conflicts and changes
- Parenting and family issues
- Child and elder care support
- Stress, anxiety and depression
- Chronic-illness and condition support
- Convenience resources
- Education resources

Face-to-face counseling

4 visits available per event per year. A network of clinicians — part of our larger network of 150,000 clinicians — provide goal-oriented counseling.

Financial coaching from experts

Up to 60 minutes of free consultation (provided in 30-minute increments) with a credentialed financial coach for each financial issue. Access to extensive legal and financial tools and libraries to help you take control of your finances.

Legal counseling and mediation services

Free 30-minute telephonic or in-person consultation with a state-specific attorney or qualified mediator per separate legal issue, via a national network of more than 22,000 attorneys and 630 professional mediators. Ongoing services are provided at 25% below the firm's current rates after the initial consultation.

Digital self-care tools

Visit liveandworkwell.com to access our digital suite of tools and resources. Discover the solutions and clinical techniques that best fit your needs to help manage stress, anxiety and other concerns all in one convenient location.

Talkspace

Support when you need it — no appointments necessary. With Talkspace, you can reach out to a licensed network EAP provider, 24/7.
To get started, call your EAP to obtain an authorization code.

Virtual Visits

HIPAA-compliant technology delivers video EAP services in the privacy and comfort of your home or wherever you choose, providing convenience and accessibility. EAP-licensed telemental health providers are available in every state.

Optum

Support for everyday life

Help is available by pone or online anytime.

Call
1-866-248-4096

Visit
liveandworkwell.com

To find the right support for you, register with your HealthSafe ID or enter your company access code: **CRH**

Connect with your EAP and WorkLife Services.

24/7 availability | Confidential | No cost to you

Your Employee Assistance Program (EAP) and WorkLife Services are available to you at no extra cost as part of your benefits. This includes **24/7 access** to EAP over the phone and online. You can call to speak with master's-level employee assistance specialists who provide consultation, risk screening, advocacy, referrals and educational materials. Or you can use our web services, which are available in English and Spanish. Search self-help information, resource databases/directories, video programs, personal empowerment programs and thousands of articles online at **liveandworkwell.com.**

CRH

Pharmacy Plan

Things to know about CVS Caremark

- Your prescription drug benefit features a formulary drug list (a list of preferred drugs). Your formulary is called the CVS Caremark Standard Control Formulary with Advanced Control Specialty Formulary and can be found online at **www.caremark.com.**
- A formulary is a list of prescription drugs, both generic and brand name, that are covered by the drug plan. Formularies are subject to change periodically. CVS Caremark updates formularies on a quarterly basis. The formulary drug list is developed by CVS Caremark identifying drugs that offer the greatest overall value. This may result in a brand name drug being excluded when a generic equivalent is covered. Generic drugs contain the same active ingredient(s) as a brand name drug.
- **CVS Caremark has a national network of pharmacies for your convenience, which includes CVS retail stores as well as most other large chains and independent pharmacies. To access the CVS Caremark pharmacy locator, please visit www.caremark.com and register with the member ID found on the front of your combined medical & pharmacy ID card. You can also locate a network pharmacy using the CVS Caremark Mobile App.**

Home Delivery

You could save time and money by getting maintenance medications by mail through CVS Caremark Mail Service Pharmacy. Enroll in CVS Caremark Mail Service Pharmacy to get up to a three-month supply of the medications you take regularly. Your medication will come right to your mailbox. To start home delivery, log into **www.caremark.com**, use the CVS Caremark App or call CVS Caremark at **800.378.0458**.

Specialty Drugs

CVS Specialty Pharmacy is part of your benefit program. CVS Specialty Pharmacy provides specialty medications and some clinical support for complex conditions, including cancer, arthritis and others. To learn more about CVS Specialty Pharmacy, call **866.846.3095** or visit **www.cvsspecialty.com**.

For CRH HDHP plan members – you will pay the full cost of the medication until the deductible has been met.

For CRH PPO plan members only – Pay $0 with the PrudentRx Copay Program:

As part of your CVS Caremark prescription plan, The PrudentRx Copay Program allows you to get all of your specialty medications at no cost to you. That means $0 out-of-pocket for any medications on your Specialty Drug List when you fill at CVS Specialty®. The PrudentRx program works with manufacturers to get copay card assistance, and will manage enrollment and renewals on your behalf. Even if there is no copay card program for your medication, your cost will be $0 for as long as you are enrolled in the program. Participation in the program is voluntary.

Retail 90-Day Refills

In order to encourage adherence and allow you to take advantage of additional savings on long-term maintenance medications (examples of maintenance medications include those for the treatment of high blood pressure, high cholesterol or diabetes) the Plan requires 90-day supply refills after three 30-day fills of these medications. You may obtain a 90-day supply at a broad network of retail pharmacies. However, you will have the choice to opt out of mandatory Retail 90-Day Refills by calling CVS Caremark.

Plan Highlights

The prescription plan for the PPO is a 4-tier plan, which includes Generic, Preferred Brand, Non-Preferred Brand, and Specialty.

The prescription plan for the HDHP(s) is a 3-tier plan, which includes Generic, Preferred Brand, and Non-Preferred Brand. The plan is integrated with the medical plan, which means the deductible for the medical plan must be met before the coinsurance/copay applies for the prescription plan. If you have a prescription for Specialty medication and you are enrolled in the HDHP Plan, you will pay the full cost of the medication until the deductible has been met. Applicable coupons may also be applied.

Women's Health Initiative: Contraceptives

Generics and over-the-counter (with a prescription) contraceptives are offered at no cost to women under the Rx plan. Over-the-counter contraceptive products will not be covered without a prescription.

CVS caremark®

CVS Caremark Customer service, retail/home delivery
www.caremark.com | 800.378.0458

CVS Specialty Pharmacy
www.cvsspecialty.com | 866.846.3095

CVS Caremark Programs and Helpful Information

Knowing your plan can help eliminate confusion or misunderstanding when filling your prescriptions. There are clinical management programs in place to help you manage your prescription needs.

The programs below include coverage details to help you make the right choices about your prescription medications.

What is Prior Authorization (PA)?

Pre-approval for certain medications before they will be covered under your plan.

Prior Authorization means that before your plan will cover a particular medication, your doctor or prescriber must show that the medication is necessary or that you have met the prior authorization requirements for the medication. Some medications must be authorized for coverage because:

- They are only approved or effective in treating specific conditions.
- There are lower-cost alternatives that are clinically equivalent and work the same.
- They may be prescribed for conditions for which safety and effectiveness have not been well established.
- PA must be renewed annually or more frequently as required.

PA ensures that medications are used correctly and it keeps pharmacy plan costs in check. If your doctor prescribes you a medication that requires a prior authorization, they will need to start the process by contacting CVS Caremark®.

What are my options if I want to use a non-formulary brand or excluded product?

If your doctor wants you to keep taking a non-formulary brand or excluded medication, your doctor can contact CVS Caremark for a prior authorization (PA). If the PA is approved, you may continue to fill your prescription(s) as usual at the non-preferred copay.

If the PA is not approved, you will have to pay the full cost of the medication(s). The amount you pay will not count toward any deductible or out-of-pocket maximum you may have.

What are Quantity Limits (QL)?

Limit on the amount of certain medications.

Quantity limits are based on the amount of medications your plan will cover over a certain period of time. This helps ensure safe and appropriate dosing and helps members get the best results from their medication therapy, while controlling healthcare costs. For example, a person may be prescribed a medication to take two tablets per day, or 60 tablets per month. If the plan has a quantity limit of 30 tablets per month for that medication, your doctor or prescriber will need to work with CVS Caremark to get authorization for a larger quantity.

What is Step Therapy (ST)?

A trial of lower-cost medication is required before a higher-cost medication is covered.

Step therapy encourages safe and cost-effective medication use. Under this program, a “step” approach is required to receive coverage for certain high-cost medications. This means that to receive coverage you may need to first try a proven, cost-effective medication before using a higher-cost medication, if needed. Step Therapy requires you to try preferred medications as the initial step in treatment before certain non-preferred medication will be covered. This lowers your cost while still providing access to non-preferred medication.

What is a Dispense as Written (DAW) Penalty?

A penalty that is applied for requesting a brand-name medication when a generic equivalent is available.

If you or your prescriber request a brand name medication when a generic equivalent is available, you will pay the applicable copayment for the brand-name medication plus a penalty.

The penalty is the difference in the plan cost between the brand-name medication that was dispensed and the generic medication that was available and could have been dispensed to you instead.

The cost difference is considered a penalty for not taking the generic medication. In order to have this penalty waived, you must have Prior Authorization or Step Therapy in place.

PrudentRx Copay Program

For PPO network participants only, the PrudentRx Copay Program allows you to get all of your specialty medications at no cost to you. That means $0 out-of-pocket for any medications on your Specialty Drug List when you fill at CVS Specialty®. The PrudentRx program works with manufacturers to get copay card assistance, and will manage enrollment and renewals on your behalf. Even if there is no copay card program for your medication, your cost will be $0 for as long as you are enrolled in the PPO network and PrudentRx program. Participation in the program is voluntary, and to make it easier, members currently taking a specialty medication will be automatically enrolled in the PPO network and PrudentRx program.

Diabetic Supplies & Equipment Under Your Healthcare Plan

Below is a list of diabetic supplies and an indication of whether they are covered under your pharmacy benefit or your medical benefit. Some drugs listed may have additional requirements or limits depending on your plan. This list is provided for your reference and may not be all-inclusive. If you have further questions, please reach out to UMR or CVS given the below contact information.

UMR Member Services: 800.826.9781 **CVS Member Services: 800.378.0458**

Therapeutic Category	Covered By	Preferred
DIABETIC EQUIPMENT		
Continuous Blood Glucose Monitoring	UMR (Medical)	Continuous Blood Glucose Monitoring (CGM) devices such as Dexcom and FreeStyle Libre, are covered under the medical plan. These monitoring devices will be covered at the applicable benefit levels below. We have also provided a list of facilities and their contact information where you can purchase these devices at the in-network rate below. **PPO & HDHP Plan** 20% coinsurance after deductible (In-Network) 40% coinsurance after deductible (Out-of-Network) **Important Note:** Pre-certification is required for DME in excess of $1,000 purchase price. Contact UMR for assistance with any additional questions.
Blood Glucose Meters	UMR (Medical)	Blood Glucose Meters are covered under the medical plan. However, OneTouch brand glucometers are available **free of charge** from the manufacturer under the "CVS Caremarks Free Meter Program" by calling the CVS Caremark Member Services Diabetic Meter Team at **800.588.4456**. We have also provided a list of facilities and their contact information where you can purchase these devices at the in-network rate below. These meters will be covered at the applicable benefit levels below. **PPO & HDHP Plan** 20% coinsurance after deductible (In-Network) 40% coinsurance after deductible (Out-of-Network) **Important Note:** Pre-certification is required for DME in excess of $1,000 purchase price. Contact UMR for assistance with any additional questions.

Diabetic Equipment Facilities		
Facility	**Website**	**Phone Number**
Byram Healthcare Centers	www.byramhealthcare.com	877.902.9726
Minimed Distribution Corp	www.medtronicdiabetes.com/home	800.646.4633
Diabetes Store, Inc.	www.diabetesinconline.com	800.501.1556
North Coast Medical Supply d/b/a/ Advanced Diabetes Supplies	www.northcoastmed.com	866.422.4866
Insulet Corporation	www.myomnipod.com	1.800.591.3455
Tandem Diabetes Care	www.tandemdiabetes.com	858.375.1473

Important Note: The manufacturer of the OmniPod insulin delivery system made the decision to supply their new product, **OmniPod 5**, through pharmacies and not through durable medical equipment (DME) distribution vendors. If you currently utilize the OmniPod 5, this product will be covered under the Pharmacy plan with CVS. Other insulin pumps are DME, covered under the medical plan.

Free Meter Program

Under your pharmacy benefit, you are eligible for a free glucose meter.

Your next steps:

1. Call the CVS Caremark Member Services Diabetic Meter Team at **1.800.588.4456**.
2. Have your prescription ID number and your doctor's name and phone number when you call.

Therapeutic Category	Covered By	Preferred	Excluded
DIABETIC SUPPLIES AND MEDICATIONS			
Diabetic Supplies (Test Strips, Needles, Syringes)	CVS (Prescription Plan)	BD Ultrafine Needle BD Ultrafine Insulin Syringes Accu-Chek Aviva Plus Strips/Kits, Accu-Chek Compact Plus Strips/Kits, Accu-Chek Guide Strips/Kits, Accu-Chek SmartView Strips/Kits, OneTouch Ultra Strips/Kits OneTouch Verio Strips/Kits	Needles: All other needles that are NOT BD Ultrafine brand Syringes: All other syringes that are NOT BD Ultrafine brand Test Strips/Kits: All other test strips/kits that are NOT Accu-Chek or OneTouch Brand
Biguanides	CVS (Prescription Plan)	metformin, metformin ext-rel (except generics for Fortamet and Glumetza)	Metformin ext-rel (generics for Fortamet and Glumetza only), Fortamet, Glumetza, Riomet
Dipeptidyl Peptidase-4 (DPP4) Inhibitors and Combinations	CVS (Prescription Plan)	Januvia, Januvia with pioglitazone, Janumet, Janumet XR	Nesina, Onglyza, Tradjenta, Jentadueto, Jentadueto XR, Kazano, Kombiglyze XR, Oseni
Glucagon-Like Peptide-1(GLP1) Agonist	CVS (Prescription Plan)	Ozempic, Rybelsus, Trulicity Victoza	Bydureon Bcise, Byetta
Insulins (Short-Acting, Long-Acting, Basal)	CVS (Prescription Plan)	Novolin 70/30*, Novolin N*, Novolin R*, Basaglar, Levemir *rebranded or private label formulations are not covered without a prior authorization for medical necessity (i.e. Relion).	Humulin 70/30*, Humulin N*, Humulin R*, Lantus NOTE: Humulin R U-500 concentrate will not be subject to prior authorization and will continue to be covered
Rapid-acting insulin	CVS (Prescription Plan)	Fiasp, Novolog, Novolog Mix 70/30	Apidra, Humalog, Humalog Mix 75/25, Humalog Mix 50/50
Insulin Sensitizers	CVS (Prescription Plan)	pioglitazone	Actos
Sodium-Glucose Cotransporter 2 (SGLT2) Inhibitors	CVS (Prescription Plan)	Farxiga, Jardiance	Invokana
SGLT2 and Biguanide Combinations	CVS (Prescription Plan)	Synjardy, Synjardy XR, Xigduo XR	Invokamet, Invokamet XR
SGLT2 and DPP4 Combinations	CVS (Prescription Plan)	Glyxambi	Qtern
Disposable Insulin Pumps	CVS (Prescription Plan)	Omnipod, V-Go	All other brands that are NOT Omnipod and V-Go

Dental Plan

If you and/or your dependents have coverage under the CRH Americas Healthcare Plan, then you and/or your dependents will be automatically enrolled and covered under the dental plan. The dental plan benefits are provided through Delta Dental.

To help limit your out-of-pocket cost, you will want to utilize network providers whenever possible. Dentists that are in the network have contractually agreed to offer their services at a lower cost, therefore reducing the amount you will pay for their services.

However, under this plan, you may use an out-of-network dentist and the plan will pay the same benefit level. Out-of-network covered expenses are subject to reasonable and customary limits that do not apply when receiving care from a network dentist. This means that your out-of-pocket expenses may be higher when using an out-of-network dentist.

When you visit the dentist for your preventive exam and cleaning the claims cost for these procedures will not be applied to your annual maximum benefit of $1,500.

PLAN PROVISION GROUP	In-Network	Out-of-Network
Deductible	Individual: $50, Family $150	
Annual Maximum	$1,500 per person, in or out-of-network combined	
COVERED SERVICES		
Diagnostic and Preventive (cleanings, fluoride, sealants, routines, x-rays)	100% of negotiated rate	100% of R&C
Basic (endodontics, periodontics, oral surgery, general anesthesia)	80% of negotiated rate	80% of R&C
Major (crowns, inlays, onlays, bridges, implants)	50% of negotiated rate	50% of R&C
Orthodontia (dependent under 19)	50% of negotiated rate	50% of R&C
Orthodontia Lifetime Maximum (dependent under 19)	$1,500	$1,500
Implants	50% of negotiated rate (after the deductible), subject to $1,500 annual maximum	
TREATMENT FREQUENCIES		
Exams, Cleaning, Periodontal Surgery/Scaling	2 per calendar year (twice in 12-month period)	
Bitewing X-ray, Fluoride (to age 12)	1 per calendar year (once in 12-month period)	
Periodontal Maintenance	2 per calendar year (twice in 12-month period)	
Full-mouth X-ray	1 in any 3 calendar years	
Sealants (to age 14)	One treatment per tooth in any 3 calendar years	
Inlay/Onlay, Crown, Dentures, Bridge	1 in any 5 calendar years	

DELTA DENTAL®

Delta Dental
www.deltadentalins.com
800.521.2651

Vision Plan

If you and/or your dependents have coverage under the CRH Americas Healthcare Plan, then you and/or your dependents will be automatically enrolled and covered under the Vision Plan. Vision benefits are provided to encourage you and your dependents to have your eyes examined regularly for the correction and the prevention of major vision problems.

You may access vision benefits by using an EyeMed network provider, or a vision care specialist of your own choice. No paperwork is involved if you use a network provider; simply pay your copayment and any expenses that are not covered. If you use a non-network provider, you will be required to pay for all expenses at the time services are rendered and will have to file a claim to receive reimbursement for any covered expenses.

Vision Care Services	What You Pay In-Network	What You Pay Out-of-Network
Exam With Dilation as Necessary	$15 copay	up to $35
Retinal Imaging	Up to $39	N/A
Frames	$0 copay, $110 allowance, 20% off balance over $110	up to $60
STANDARD PLASTIC LENSES		
Single Vision	$20 copay	up to $30
Bifocal	$20 copay	up to $50
Trifocal	$20 copay	up to $65
Standard Progressive Lens	$20 copay	up to $50
Premium Progressive Lens	$20 copay 80% of charge less $120 allowance	up to $50
LENS OPTIONS		
UV Treatment, Tint (solid/gradient), Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate – Adults and Children under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized and Other Add-Ons and Services	20% off retail	N/A
CONTACT LENS FIT AND FOLLOW-UP		
Standard Contact Lens Fit and Follow-Up	up to $55	N/A
Premium Contact Lens Fit and Follow-Up	10% off retail price	N/A
CONTACT LENSES (contact lens allowance includes materials copay)		
Conventional	$20 copay. $100 allowance, 15% off balance over $100	up to $90
Disposable	$20 copay. $100 allowance plus balance over $100	up to $90
Medically Necessary	$0 copay paid in full	up to $180
LASER VISION CORRECTION		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Prescription Safety Glasses	20% off retail	N/A
FREQUENCY		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	

EyeMed
www.eyemedvisioncare.com
866.723.0513

2024 Employee Contributions

CRH Americas pays the majority of the cost for your benefits. The amount you pay will depend on the benefit choices you select. At CRH Americas, we value our employees and understand the importance of providing high-quality benefits at affordable rates. Below are the annual and monthly contribution rates for each of the plans and tiers:

All contributions include medical, prescription, dental and vision benefits

	Employee Contributions	
Employee Tier	**PPO Plan Standard Rate**	
	Annual Rate	**Monthly Rate**
Employee Only	$2,040	$170
Employee + Spouse	$4,200	$350
Employee + Child(ren)	$3,660	$305
Family	$5,880	$490
Employee Tier	**HDHP Plan Standard Rate**	
	Annual Rate	**Monthly Rate**
Employee Only	$1,128	$94
Employee + Spouse	$2,220	$185
Employee + Child(ren)	$1,944	$162
Family	$2,940	$245

NOTE: The premium rates listed above are annual and monthly rates taken on a pre-tax basis from payroll. Your payroll deductions may vary based on your company-specific payroll frequency and any deductions credits and surcharges that pay apply (see below). However, because these premiums are collected on a pre-tax basis the IRS restricts enrollment changes to annual open enrollment or within 60 days of a qualified life event.

Wellness Credit

The Wellness credit for a premium reduction in 2024 applies only to employees and their covered spouses who completed the required wellness visit between September 1, 2022 and August 31, 2023. To qualify for the 2025 wellness credit, your wellness visits need to be between September 1, 2023 and August 31, 2024.

If the employee only completed the wellness initiative, the credit is $25 per month.

If both the employee and their covered spouse completed the wellness initiative, the credit is $50 per month. The employee is required to complete the initiative in order for the spouse to receive credit.

Spousal Surcharge

Most companies offer medical coverage to their employees. To manage our costs more efficiently, and to benefit our employees, we encourage working spouses to enroll in their company's plan. If your spouse is eligible for his or her company's medical coverage, and he or she chooses not to enroll and subsequently enrolls in the CRH Americas plan, you will be responsible for paying the spousal surcharge for an additional $225 per month for the PPO plan or $175 per month for the HDHP plan.

IMPORTANT: A Spousal Surcharge Waiver MUST be completed each year during Open Enrollment or during your initial enrollment period, the waiver does not carry forward year to year.

Qualifications to waive the spousal surcharge

- Spouse's employer does not offer medical coverage or your spouse is not eligible
- Spouse is self-employed and has no coverage available
- Spouse is not employed
- Spouse works at CRH Americas
- Your spouse is covered by Medicare or other government plan and not also covered by an employer plan

If any of the above apply, then the spousal surcharge does not pertain to you and a spousal surcharge waiver must be completed. You must do this online at **www.benefitsolver.com** or call the CRH Americas Benefits Helpline at **888.437.4866** during the enrollment process each year to avoid the spousal surcharge deduction.

Wellness Initiative

CRH Americas Healthcare Plan

In an effort to encourage the health and wellness of our employees, CRH will offer a wellness credit.

Who is eligible?

Employees and their spouses who are covered on the CRH Americas Healthcare Plan are eligible to participate in the wellness initiative and must complete a physical exam or age appropriate physical exam during September 1, 2023 through August 31, 2024 for the premium reduction to be applied in 2025.

Employees and spouses who are eligible and added to the plan on or after July 1, 2024 through August 31, 2024 will not be required to complete the wellness exam during the current cycle to receive the premium reduction in 2025.

Employees and Spouses that complete or have completed the initiative will pay $25 a person, up to $50 less per month on the 2024 employee contributions. The employee **MUST** complete the initiative in order to receive the premium reduction for the spouse. If the covered spouse completes the initiative, but the employee does not, no premium reduction will be awarded.

How is the initiative verified?

Our medical insurance carrier will verify completion of your physical exam.* Employees/spouses need not provide any information to CRH.

**Verification by medical insurance carrier is based on provider applying the proper coding.*

Must I wait 12 months between physicals?

No, the CRH Americas Plan does not have a restriction on the time between physicals.

Can I check to see if my wellness exam has been verified?

Yes, you can check your account at **www.benefitsolver.com.**

- You will see the Wellness Tracker on the home page.
- Click the “View” button to review your wellness information.
- If you have completed your wellness initiative, you will see “Yes” populated for **Wellness Credit Employee.**
- If your spouse has completed the wellness initiative, you will see “Yes” populated for **Wellness Credit Spouse.**
- You will see the total amount of eligible credit as “Wellness Rollup” located at the top of the tracker.
- *Please allow for lags in timely claim submissions by providers. If you don’t see your credit immediately after your wellness visit be sure to check back periodically to see if the update has been received.*

Examples of physical exams

Examples of age-appropriate physical exam may include:

- Blood panel: Total Cholesterol level, both LDL and HDL
- Glucose level (for non-diabetics)
- A1c level (for diabetics)
- Blood pressure

Or any one of the following screenings:

- Mammogram
- Pap Smear
- Colorectal Screening

MyChoice Accounts (MCA)

Health Savings Account (HSA)

The HDHP medical plan offered by CRH Americas meets certain IRS requirements that allow employees who enroll and open a Health Savings Account (HSA). An HSA allows you to contribute pre-tax payroll deductions that you can then use to pay for qualified expenses.

What is a Health Savings Account (HSA)?

Money funded to this account can be used to pay for qualified healthcare out-of-pocket expenses for you and your eligible dependents.

After enrolling in the HSA, whether you contribute to the account or not, CRH Americas will contribute portion to the HSA account. **To receive the employer portion, you must elect the HSA with an election of $0 or greater.** Combined employee and employer contributions to the HSA cannot exceed the annual limits set by the IRS.

The funds in your HSA may be utilized today, rolled over into the upcoming year, or invested to help pay for future qualified expenses.

Who's eligible to enroll/contribute to an HSA?

You're eligible to enroll and/or contribute to an HSA if:

- You elect the CRH qualified high-deductible health plan (HDHP) for 2024.
- Your only coverage is an HDHP.
  - If you're covered under your spouse's plan and that plan is not a qualified HDHP, you are not eligible to contribute to an HSA.
- You are not covered by a traditional Healthcare FSA through your spouse.
- You are not covered by Medicare (part A or B), Tricare or VA Benefits*.
- You cannot be claimed as a dependent on another person's tax return (unless it's your spouse).

*Veterans with a disability rating of 10% or greater who receive hospital care or medical services from the Veterans Administration are now eligible to make contributions to an HSA.

How do I enroll?

After you have enrolled in the HDHP in BenefitSolver, you can enroll in the Health Savings Account. You will need to answer a few questions online to ensure you are eligible to open and/or contribute to an HSA. If you are eligible, and elect your account will automatically be opened with the banking custodian, UMB Bank.

When your HSA is opened, there are instances when you may need to verify your identity.

As with any other banking requirement, employees will be required to comply with the **Customer Identification Program (CIP)** for identity verification. Financial institutions are required under CIP to obtain and verify specific customer data information in order to comply with the US Patriot Act of 2003. This data includes name, date of birth, SSN and residential address (cannot be a PO Box). In the majority of enrollments this information will pass without instance. However, any conflicting information will need to be verified by the employee. You must satisfy this process in order to make or receive contributions to an HSA.

Can I enroll in both an HSA and Flexible Spending Account (FSA)?

If you are covered by a traditional Healthcare FSA, you are not eligible to open and/or contribute to an HSA. However, you may choose to participate in an HSA-Compatible FSA and still be eligible to open and/or contribute to an HSA. In an HSA-Compatible FSA, your FSA funds may only be used for dental and/or vision expenses until your medical calendar-year deductible has been met. Once your deductible has been met, you may submit the proper documentation and then use your FSA for medical and/or prescription expenses.

Enrollment Tier	2024 IRS Annual Maximum (CRH Americas + Member Contribution)	CRH Americas Annual Contribution	Member Annual Contribution
Employee Only	$4,150	$500	Minimum: $0 Maximum: $3,650
Employee + Child	$8,300	$750	Minimum: $0 Maximum: $7,550
Employee + Spouse	$8,300	$750	Minimum: $0 Maximum: $7,550
Employee + Children or Employee + Family	$8,300	$1,000	Minimum: $0 Maximum: $7,300

Catch-up contributions: If you are age 55 or older as of December 31, 2024, you can contribute an extra $1,000 per year.
Annual Maximum is subject to change by the IRS on an annual basis.

When are my HSA funds available to me?

Unlike an FSA, your total election amount is not available to you January 1. Rather, your account balance builds throughout the year based on your payroll deductions and/or CRH's contributions, and you may only withdraw funds to pay for qualified expenses based on the actual account balance.

Can I change my HSA contribution during the year?

Yes, you can increase or decrease your HSA contribution at any point during the year as long as you do not exceed the total maximum annual contribution amount.

What can I use HSA funds for?

You can use the funds you accrue to pay for IRS-qualified expenses such as:

- Medical and prescription drug expenses
- Dental care services
- Vision care services
- Over-the-counter medications with written prescription from your doctor
- Certain medical equipment
- Long-term care and long-term care insurance premiums
- COBRA premiums
- Medicare insurance premiums and premiums under an employer-sponsored retiree medical program (once you reach age 65)

How do I access my HSA funds to pay for qualified expenses?

When you enroll in the HDHP and open an HSA, you will receive a MyChoice Accounts Card to use at your discretion for qualified expenses. This way, you can choose to use the funds or build the balance in your HSA to save for unexpected expenses, or even save toward retirement.

If you have an HSA account from a prior employer, you can transfer the funds to your CRH HSA by contacting your HSA account provider.

What are the Investment Options?

Your investment choices include standard investment options, which range from high, moderate, or low-risk investment choices to maximize your savings.

MyChoice Accounts has partnered with an FDIC-insured bank, UMB Bank as your HSA custodian.

You will have access to an integrated account and investment management on **www.benefitsolver.com**.

- No additional enrollment or separate site access is required to invest.
- Mutual funds with no per-trade fees.
- Automatic fund allocation capabilities.
- 24/7 access to statements and tax forms.

Are there administrative fees associated with an HSA?

If you choose to invest your funds, which you are immediately to start investing, a $2.50 monthly administration fee, charged by UMB Bank, is deducted directly from your account balance.

When you start investing the money in your HSA, you will not pay taxes on your gains.Your interest and investment income earned on the HSA balance are also taxfree, allowing you to build your balance tax-free.

mychoice™ Accounts

Flexible Spending Accounts

	Healthcare Flexible Spending Account	HSA-Compatible Healthcare Flexible Spending Account
Eligibility Requirements	You can use this account for eligible expenses including health, dental and vision expenses not covered by insurance that you or your dependent incurs • Must be enrolled in Medical PPO Plan	You can use this account for eligible dental and vision expenses not covered by insurance that you or your dependent incurs. • Anyone not enrolled in a PPO Medical Plan
What would I use this account for?	Deductibles, copays, and coinsurance for medical, dental, vision, or prescription drug expenses Any IRS eligible expense	Deductibles, copays, and coinsurance for dental or vision expenses Any IRS eligible expense
What is the maximum amount that I can put in this account?	Minimum Election: $250 Maximum Election: $3,050	Minimum Election: $250 Maximum Election: $3,050
How do I enroll?	Enrollment can be completed at **benefitsolver.com**, you will receive a debit card in the mail once enrollment is completed. Enrollment elections cannot be changed until the next enrollment period or if you have a qualified life event. You must re-elect FSA coverage every year, enrollment does not carry forward year to year.	
When are the funds available?	Your total contribution amount is front loaded into your account by CRH Americas and immediately available for use. However, your contributions are deducted in equal installments from each paycheck throughout the year. The money you contribute to the account on a pre-tax basis is not taxed when you use it for eligible expenses.	
What happens if I don't use the money during the year?	The Healthcare FSA will allow you to automatically carry over up to $610 of any balance remaining at the end of 2024 to be used in 2025. The $610 carryover will not affect the $3,050 limit for contributions in 2025. No need to rush to spend the carryover dollars—there is no deadline in 2025 to spend the amount carried over.The minimum balance required for carryover is $10 for participants who do not enroll in the Health Care Flexible Spending Account for the next plan year.	
When do I need to submit documentation?	The IRS requires MyChoice Accounts to verify every purchase. We do that by approving your card swipes at the point of sale and paying your provider. But sometimes the provider is not registered in the merchant coding system, or we can't validate the service or item you purchased with the information given to us. For example, if your dentist's office didn't specify what service you received, we would need documentation to make sure that it's an eligible expense. Teeth whitening is not an eligible expense, for instance. Just in case you need to submit documentation, make sure to save all your receipts for purchases and the explanations-of-benefits document that you get from the insurance company. The five different kinds of documentation you can utilize to submit are: An explanation-of-benefits (EOB) document that you received from your insurance company. A detailed receipt showing the items or services you received from the retailer or provider. An invoice from your provider. Don't submit canceled checks or bank statements because they usually don't provide enough information. Also, you cannot submit your own notes as documentation.	

Card substantiation: All Healthcare Card purchases have to be verified within 90 days of the transaction date in accordance with IRS regulations. MyChoice Accounts will notify you if the transaction cannot be automatically verified and provide you with instructions for how to proceed.

benefitsolver

www.benefitsolver.com
888.437.4866

Dependent Day Care Flexible Spending Account

	Dependent Day Care Flexible Spending Account
Eligibility Requirements	The Dependent Day Care FSA is available to employees wishing to set aside pre-tax dollars to pay for day care expenses for eligible dependents. Eligible dependents are defined as children under the age of 13 who qualify as dependents on your federal income tax return, or a disabled spouse or disabled dependent age 13 or older who is physically or mentally incapable of self-care. Verification of disability is required. In order to be eligible for this account, you must meet one of the qualifying criteria: • You and your spouse both work • You are a single head of household • Your spouse is disabled or a full-time student
What would I use this account for?	Eligible expenses include direct supervision of the dependent(s) and expenses for household services. Most kinds of direct supervision are covered, including: • Care in a dependent care center. If the facility provides care for over six individuals, the center must comply with applicable local laws and regulations • Dependent day care provided by an individual in your home or theirs • Dependent day care provided in an educational institution
What is the maximum amount that I can put in this account?	Minimum election: $250 Maximum elections: $5,000 If you are single $5,000 If you are married and filing jointly $2,500 If you are married and filing separate tax returns
How do I enroll?	Enrollment can be completed at **benefitsolver.com**, you will receive a debit card in the mail once enrollment is completed. Enrollment elections cannot be changed until the next enrollment period or if you have a qualified life event. You must re-elect FSA coverage every year, enrollment does not carry forward year to year.
When are the funds available?	Your contribution amount is available as it comes out of your paycheck each pay period — so your entire contribution amount is not available at the beginning of the year or when coverage starts.
What happens if I don't use the money during the year?	You have a grace period until March 15 of the following year in which you may incur expenses using your previous year's FSA funds. You will have until March 31 (including the grace period) to apply for reimbursement of eligible expenses. Any funds remaining in your Dependent Day Care FSA after March 31 that could have been used for eligible expenses incurred during the previous year will be forfeited, as required by the IRS.

NOTE: Manually submit claims January - March for prior year expenses. Supporting documentation needs to be submitted to substantiate prior year claims.

Nondiscrimination Testing

Because your FSA contributions are deducted from your paycheck pre-tax, CRH Americas must conduct testing of our Healthcare and Dependent Day Care FSAs to ensure they do not discriminate in favor of individuals who are either highly compensated employees or are otherwise key employees within our organization. In the event that the plan(s) fail the testing, CRH Americas reserves the right to change your contribution mid-year to realign the plan(s) to a passing status. See your FSA Summary Plan Description for more information.

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Life Insurance

Basic Life and AD&D Benefits for Employee

Basic Life and Accidental Death and Dismemberment (AD&D) benefits are provided at no cost to you through Unum. You receive coverage of one times your annual base pay rounded up to the nearest $1,000 up to a maximum benefit of $500,000.

Accidental Death and Dismemberment (AD&D) pays additional benefits to your family and/or beneficiaries if your death results from an accident. AD&D coverage also provides you a portion of your benefits if you lose a limb, sight, hearing or speech as a direct result of an accident. Please be sure to keep your beneficiary information up to date. The Basic and Optional Summary Plan Document can be accessed on the main landing page on Benefitsolver.

Note: Amounts over $50,000 will be taxed as imputed income.

Optional Life for Employees

You can enhance your basic life insurance benefit by purchasing additional life insurance for yourself. Your contributions will be paid on an after-tax basis based on IRS rules. You can buy optional life in $10,000 increments up to 10 times your annual earnings not to exceed $2,000,000. The monthly rates per $1,000 of optional life coverage are listed in the chart on this page. Evidence of Insurability is required.

Guarantee Issue

New Hire: You are eligible for up to $300,000 and Spouses are eligible for up to $50,000 without Evidence of insurability (EOI).

Open Enrollment: During annual Open Enrollment current eligible full-time employees have the option to elect or increase $10,000 of coverage, without evidence of insurability.

Enrollment is available year-round; however, enrollment outside your initial new hire enrollment period is considered a late entrant and is subject to EOI.

Optional Life for Spouses

You have the opportunity to purchase life insurance for your spouse in increments of $10,000 up to a maximum of $250,000. Evidence of insurability is required.

Rates are based on age and use of tobacco or not. Rates apply to employee age and spouse age independently.

Optional Life for Dependents

You have the opportunity to purchase life insurance for your dependent children (live birth to age 26). You may elect a flat amount of $10,000 of coverage. The cost for covering dependents is $1.32 per month and covers the cost for all of your dependent children regardless of the number of children. No evidence of insurability is required.

Note: Employee optional life coverage is not required for spouse/dependent optional life elections (subject to limits).

Monthly Rates Per $1,000 of Coverage

Attained Age	Non-Tobacco	Tobacco Use
Under Age 25	$0.051	$0.062
25-29	$0.062	$0.071
30-34	$0.082	$0.095
35-39	$0.093	$0.107
40-44	$0.103	$0.119
45-49	$0.154	$0.187
50-54	$0.237	$0.286
55-59	$0.442	$0.559
60-64	$0.679	$0.893
65-69*	$1.307	$1.788
70-74*	$2.119	$2.900
75+	$2.119	$2.900

*Amount of coverage will be limited at or above age 70.

You must be actively at work following the effective date for coverage or any increase in coverage to be applicable. You are not considered actively at work if you are on any leave of absence such as disability or workers compensation, on the effective date of coverage. The only exception to this requirement is if you are on an inactive seasonal layoff.

Did You Know?
If you leave CRH Americas, you will have the option to port or convert your or your dependents life insurance. This means you may continue to purchase the insurance by paying the premiums on your own. You have only 90 days from your termination date to transition the plan. Contact Unum for more information. Dependent children, who attain age 26 during the plan year, will be covered on the Optional Dependent Life Plan through the end of the calendar year of their 26th birthday.

unum sm

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866.215.1720

Calculating Your Optional Life Cost

	Coverage Amount		Number of 1,000s		Premium		Monthly Cost
You		÷ ,1,000 =		x		=	$
Spouse		÷ ,1,000 =		x		=	$
Children		÷ ,1,000 =		x		=	$

Optional Life Insurance Plan Additional Information

Coverage is based on annual earnings

Employee annual earnings as of October 1 of each year are used to calculate rates and determine coverage for the following plan year commencing on January 1. Adjustments may be made if you have a salary increase of 15% or greater.

Benefit reduction for Age 70 and 75

When an employee turns age 70 or 75, benefits will be reduced and the current election will be frozen at 65% and 50% respectively. This reduction is applicable to Basic Life and Optional Life Coverage for employees and Optional Life Coverage for spouses. When an employee's spouse turns age 70 or 75, benefits will be reduced and frozen at 65% and 50%, respectively, of their current election.

The employee's total premium paid for Optional Life will be reflected in the reduction of benefits. The age and benefit levels will be determined in January of each year for rates and coverage for the plan year commencing on January 1.

Should the employee/spouse turn age 70 or 75 after January 1, their rate and coverage will not change until the following plan year.

Short-Term and Long-Term Disability Plans

Unum manages both the CRH Americas Short-Term and Long-Term Disability Plans. These plans are provided to all eligible full-time employees. The waiting period for eligibility is first of the month following 60 days of continuous active employment.

Unum has a dedicated team of highly trained representatives who are well-versed in disability claims management and are familiar with CRH Americas' plan. Unum is committed to excellent customer service and making claims submission easy by allowing you to report a claim by telephone or online.

Questions	Short-Term Disability (STD)	Long-Term Disability (LTD)
Who pays for the coverage?	CRH Americas	CRH Americas
What is the benefit?	60% of weekly earnings up to $2,000 (subject to taxes)	60% of monthly earnings up to $10,000
How are my benefits calculated?	• **For Salaried employees,** your benefit calculation is determined by looking at your gross monthly income in effect as of October 1 of the prior year. • **For Hourly employees,** your benefit calculation is determined using your hourly rate of pay as of October 1 of the prior year multiplied by 2,080 hours and then divided by 12 months. • **For Commissioned employees** your gross monthly income from your Employer in effect as of October 1 of the prior calendar year just prior to your date of disability. It is calculated as the sum of your annual base salary (if applicable) as of October 1 and income actually received from commissions for the period of October 1 through September 30 of the prior calendar year divided by 12 months.	
Elimination Period	7 days for Illness and Injury	26 weeks
How often will I receive my disability income?	Weekly	Monthly
How do I report a disability claim?	Telephonically **866.215.1720** or online at **www.unum.com**	Telephonically **866.215.1720** or online at **www.unum.com.** If you are receiving benefits for STD, your claim will be transferred to LTD automatically. If you are on Workers Compensation, you will need to initiate an LTD claim if you have missed 90 days and expected to continue to be disabled.
Must I communicate with my local HR/Benefit Administrator to coordinate my leave?	Yes, as you could also be eligible for benefits under the FMLA.	Yes, so you can determine if anything changes with your health and other related benefits when you start receiving LTD benefits.
How is the FMLA process handled?	This will be handled by Unum and your local HR/ Benefit Administrator to coordinate your leave.	FMLA may not apply once you start receiving LTD benefits, but if you still have FMLA-related leave available, you will still need to communicate with Unum and the local HR/Benefit Administrator to coordinate your leave.
Will my disability benefits offset with benefits available with State Disability?	Yes, the benefit you receive from state disability could offset against the STD amount.	Yes, the benefit you receive from state disability could offset against the LTD amount.

A fact sheet on the Short-Term and Long-Term Disability Plans and an outline of the Telephonic Claim Process are available on **www.benefitsolver.com.**

If you are represented by a union, you may or may not be eligible for this benefit; your eligibility for this plan is dependent upon your specific collective bargaining agreement.

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866.215.1720

CRH Americas 401(k) Retirement Plan

Plan Provisions	
Auto Enrollment	New employees will be subject to automatic enrollment at a 5% deferral rate on their eligibility date unless they opt out of participation. Employees will receive a notice 30 days prior to their eligibility date notifying them of the auto enrollment.
Eligibility	**Employee Deferral Contribution:** First day of the month after 90 days of employment **Employer Match Contribution:** First day of the month after meeting all eligibility requirements One year of service from date of hire **Employer Profit Sharing Contribution:** First day of the month after meeting all eligibility requirements One year of match eligible service from date of hire, 1,000 hours of service in plan year and employed on the last day of the plan year
Employee Contribution	You may contribute in whole percentage amounts from 1% to 75% on a Traditional pre-tax and Roth post-tax, subject to IRS maximum limits
Employer Contribution	**Matching contribution:** CRH Americas will match 100% of the first 5% you contribute **No True-up:** The CRH plan does true-up the employer match to the 401(k). The match is aligned with the employee's per pay period contributions. If the annual limit is met during the year, the match will stop. **Profit Sharing contribution:** CRH Americas may contribute a percentage of your eligible compensation, at its discretion
Vesting	
Employee Deferral Contribution	Immediately
Employer Match Contribution	Immediately
Employer Profit Sharing	20% per year of credited service; 100% after five years of service
Administered by	Fidelity Investments | 800.835.5095 | www.401k.com

Some groups including unions may have a different contribution schedule or may not be eligible for profit sharing and employer matching contributions. Please contact your local HR/Benefits Representative with questions regarding profit sharing and matching contributions.

401(k) Plan Highlights

This summary is intended to provide you with general information about the retirement benefits provided for you by CRH Americas. For additional information about the CRH Americas 401(k) Plan (the Plan), visit Fidelity NetBenefits® at **www.401k.com** or call **800.835.5095**. Please keep in mind that some groups including unions may have different eligibility requirement or contribution schedules. You may want to consult your local HR representative for plan specific information.

Who is eligible?

Your eligibility to participate in the Plan depends on the date you were first hired by a participating employer, your status in a group of employees covered by the Plan, and the types of contributions involved. You will become eligible to participate in the plan on the first day of the month following the date you turn 18 and complete 90 days of service with your employer. You will be eligible for safe harbor matching and non-elective contributions (i.e. profit sharing), to the extent made, on the first day of the month following the date you turn 18 and complete one year of service (generally, 1,000 hours during the 12-month period beginning on your date of hire with your employer or a related company). To receive an allocation of non-elective contributions for a Plan year, you must have one year of match eligible service, be employed by a participating employer or related company on the last day of the Plan year (December 31) and have at least 1,000 hours of service during the Plan year. You may also be eligible for non-elective contributions if, during the Plan year, you retire, pass away or become disabled. You are not eligible for safe-harbor matching contributions or non-elective contributions if you are subject to a collective bargaining agreement that does not provide for you to receive such contributions. Other Plan provisions and limitations may be governed by the terms of your collective bargaining agreement.

Automatic Enrollment

If you are a non-bargained employee (or an employee covered by a bargaining agreement that provides for automatic enrollment) that becomes eligible on or after January 1, 2022 (when the policy was put into place), and you fail to make a specific election to contribute (or not contribute) to the Plan, you will be automatically enrolled on the first day of the calendar month following the day you have attained age 18 and complete 90 days of service with a participating employer. **You will have 5% of your Plan compensation withheld from your pay and contributed to the Plan as 401(k) contributions.** Unless you choose investment options, the automatic 401(k) contributions will be invested in the Plan's qualified default investment alternative fund. This percentage will remain constant from Plan year to Plan year unless you change it.

Remember, you have the right to elect out of automatic enrollment. If you want to increase or decrease your 401(k) contributions, invest in a different investment fund, or have no contributions made to the Plan, you can make an election by calling the Fidelity Retirement Benefits Line at **800.835.5095** or online through Fidelity NetBenefits® at **www.401k.com**.

How do I access and enroll in the Plan?

You can access your account online through Fidelity NetBenefits® at **www.401k.com** or call the Fidelity Benefits Center at **800.835.5095** to speak with a representative or use the automated voice response system, virtually 24 hours, 7 days a week and enroll in the plan.

When is my enrollment effective?

Your enrollment becomes effective once you elect a deferral percentage, which initiates deduction of your contributions from your pay. These salary deductions will generally begin with your next pay period after we receive your enrollment information, or as soon as administratively possible.

How do I designate my beneficiary?

If you have not already selected your beneficiaries, or if you have experienced a life changing event such as a marriage, divorce, birth of a child, or a death in the family, it's time to consider your beneficiary designations. Fidelity's Online Beneficiaries Service, available through Fidelity NetBenefits®. offers a straightforward, convenient process that takes just minutes. Simply log on to NetBenefits® at **www.401k.com** and click on "Beneficiaries" in the "About You" section of "Your Profile". If you do not have access to the internet or prefer to complete your beneficiary information by paper form, please contact **800.835.5095**. Your beneficiary designation will not transfer from your prior plan.

How much can I contribute?

CRH Americas offers you the opportunity to make both a Traditional pre-tax 401(k) and/or Roth post-tax 401(k) contribution. Through automatic payroll deduction, you can contribute between 1% and 75% (in 1% increments) of your eligible pay on a pre-tax and/or post-tax basis, up to the annual IRS dollar limits. Annual additions to the plan (your contributions and company contributions combined) may not exceed 100% of your pay or $69,000 for 2024 (whichever is less). In addition, you can automatically increase your retirement savings plan contributions each year through the Annual Increase Program, up to 75% of pay. You can sign up by logging on to Fidelity NetBenefits® at **www.401k.com** and click on "Payroll Deductions" or by calling the Fidelity Benefits Center at **800.835.5095**. Employees determined to be highly compensated may have additional limitations.

What are the maximum IRS annual contribution limits?

For 2023 the IRS pre-tax and/or post-tax contribution limit is $23,000 for participants under age 50. The 2024 pre-tax and/or post-tax catch-up contribution limit is an additional $7,500 for participants age 50 and older or a total of $30,500.

What "catch-up" contribution can I make?

» As long as you have reached or will reach age 50 during the plan year and have made the maximum plan or IRS pre-tax and/or post-tax contribution of $23,000 your deferral percentage may continue to defer up to the annual catch-up limit of $30,500. These will be automatically classified as catch-up contributions. A separate catch-up contribution election is not necessary. Catch-up contributions are made through payroll deduction, the same as regular contributions.

Does the Company make a matching contribution to my account?

CRH helps your retirement savings grow by matching your contributions. CRH will match 100% of each dollar you contribute on the first 5% of pay that you defer to your Plan. In general, employees must be employed for 12 months from date of hire to meet the initial eligibility for matching contributions. Matching contributions will begin on the 1st day of the month following eligibility. If you are covered by a collective bargaining agreement your matching contribution will be defined by the union specific agreement.

Will the Company make a profit sharing contribution?

CRH may make an annual profit sharing contribution to your account. In general, an employee must have one year of match eligible service from date of hire, have 1,000 hours of service in the plan year, and must be employed on the last day of the plan year to be eligible to receive profit sharing. If you have any questions concerning this profit sharing contribution, please contact your local human resources department. If you are covered by a collective bargaining agreement your profit sharing contribution will be defined by the union specific agreement.

Plan Compensation

Contributions to the Plan are based on Plan compensation. Your "Plan Compensation" that is eligible for 401(k) contributions consists of all wages paid to you as an eligible employee for services rendered as reported on your Form W-2, exclusive of reimbursements and other expense allowances, fringe benefits, moving expenses, deferred compensation, welfare benefits and bonuses. Plan compensation does not include severance pay. Plan compensation includes any amounts that would have been included in your compensation if they had not received special tax treatment because they were deferred under the Plan, a medical reimbursement plan, dependent care plan or for qualified transportation or parking expense reimbursements. Tax rules limit the amount of compensation that may be taken into account as plan compensation each year ($345,000 for 2024).

When am I vested?

You are always 100% vested in your pre-tax and/or post-tax contributions, rollover contributions and any associated earnings. Any company matching contributions made to your account after January 1, 2013 and any associated earnings will also be 100% vested. Any company profit sharing contributions made to your account and any associated earnings will vest according to the following schedule:

Years of employment	Vested percentage
1	20%
2	40%
3	60%
4	80%
5	100%

What are my investment options?

To help you meet your investment goals, the Plan offers you a range of options. You can select a mix of investment options that best suits your goals, time horizon, and risk tolerance. The investment options available through the Plan include conservative, moderately conservative, and aggressive funds. The plan also includes investment options in company stock and as well as a self-directed brokerage account. A complete description of the Plan's investment options and their performance, as well as planning tools to help you choose an appropriate mix, are available online at Fidelity NetBenefits®.

How do I know if my money will last through retirement?

Fidelity's planning tools are designed to help you manage your assets as you plan for retirement. Simply log on to Fidelity NetBenefits® at **www.401k.com** to access these tools.

Can I take a loan from my account?

Although your plan account is intended for the future, you may borrow from your account for any reason. Generally, the Plan allows you to borrow up to 50% of your pre-tax and/or post-tax account balance and rollover account balance. The minimum loan amount is $1,000, and a loan cannot exceed the lessor of $50,000 or 50% of your pre-tax and/or post-tax and rollover account balance. You then pay the money back into your account, plus interest, through after-tax payroll deductions. Any outstanding loan balances over the previous 12 months may reduce the amount you have available to borrow. You may have one loan outstanding at a time. The cost to initiate a loan is $50, and there is a quarterly maintenance fee of $6.25. The initiation and maintenance fees will be deducted directly from your individual plan account. If you fail to repay your loan (based on the original terms of the loan), it will be considered in "default" and treated as a distribution, making it subject to income tax and possibly to a 10% early withdrawal penalty. Defaulted loans may also impact your eligibility to request additional loans. Be sure you understand the Plan guidelines before you initiate a loan from your plan account. To learn more about or request a loan, log on to **www.401k.com** or call the Fidelity Benefits Center at **800.835.5095**.

Can I make withdrawals from my account?

Withdrawals from the Plan are generally permitted when you terminate your employment, retire, reach age 59½, become permanently disabled, or have severe financial hardship as defined by your Plan. The taxable portion of your withdrawal that is eligible for rollover into an individual retirement account (IRA) or another employer's retirement plan is subject to 20% mandatory federal income tax withholding, unless it is rolled directly over to an IRA or another employer plan. (You may owe more or less when you file your income taxes.) If you are under age 59½, the taxable portion of your withdrawal is also subject to a 10% early withdrawal penalty, unless you qualify for an exception to this rule. To learn more about and/or to request a withdrawal, log on to Fidelity NetBenefits® at **www.401k.com** or call the Fidelity Benefits Center at **800.835.5095**. The plan document and current tax laws and regulations will govern in case of a discrepancy. Be sure you understand the tax consequences and your plan's rules for distributions before you initiate a distribution. You may want to consult your tax adviser about your situation. When you leave the Company, you can withdraw contributions and any associated earnings or, if your vested account balance is greater than $5,000, you can leave contributions and any associated earnings in the Plan. After you leave the Company, if your vested account balance is equal to or less than $1,000, it will automatically be distributed to you. If your account balance is greater than $1,000 but less than $5,000, your account will be rolled over to a Fidelity Individual Retirement Account (IRA).

When will I receive my statement?

Quarterly statements are available online. Upon initial login to NetBenefits participants will be requested to consent to online delivery. Participants who decline consent will be reverted to paper statement delivery. All other participants (those who have not logged onto NetBenefits) will default to online statement delivery. Participants have the option to revert to paper at any time by making an election through Fidelity NetBenefits® at **www.401k.com** or calling the Fidelity Benefits Center at **800.835.5095**. Participants using online statement delivery (either by default or by their election) will be sent a Notice of Statement Availability (NOSA) in the mail annually.

Plan Administrative Fees and Expenses

Plan administrative fees may include legal, accounting, trustee, recordkeeping, and other administrative fees and expenses associated with maintaining the Plan. The participant administrative fee in the amount of $14 annually ($3.50 per quarter) will be deducted from each account on a quarterly basis. This fee may be subject to change periodically. Should you have questions or wish to speak with a Fidelity Service Representative, please call **800.835.5095**.

Where can I find information about exchanges and other plan features?

Once you enroll, you will receive a welcome communication that provides details about managing your account. You can also learn about loans, exchanges, and more, online through Fidelity NetBenefits® at **www.401k.com**. In particular, you can access loan modeling tools that illustrate the potential impact of a loan on the long-term growth of your account. You will also find a withdrawal modeling tool, which shows the amount of federal income taxes and early withdrawal penalties you might pay, along with the amount of earnings you could potentially lose by taking a withdrawal. You can also obtain more information about loans, withdrawals, and other plan features, by calling the Fidelity Benefits Center at **800.835.5095** to speak with a representative or use the automated voice response system, virtually 24 hours, 7 days a week.

What are my rights in respect to Mutual Fund Proxy Voting?

As a Plan participant, you have the ability to exercise voting, tender, and other similar rights for mutual funds in which you are invested through the Plan. Materials related to the exercise of these rights will be sent to you at the time of any proxy meeting, tender offer or similar rights relating to the particular mutual funds held in your account.

How do I obtain investment option and account information?

The Company has appointed Fidelity to provide additional information on the investment options available through the Plan. Also, a statement of your account may be requested by phone at **800.835.5095** or reviewed online at Fidelity NetBenefits®.

Updated 11/15/2023

Accessing Your Fidelity 401k Account

SET UP YOUR 401K ACCOUNT ONLINE OR BY CALLING FIDELITY

Access your account online through Fidelity NetBenefits at **www.401k.com** OR call the Fidelity Benefit Center at **800.835.5095** to speak with a representative.

REVIEW YOUR ACCOUNT

Review your account balances, and your contribution amount, and investments.

- Log in to **www.401k.com**
- Click Quick Links, then Select Summary

UPDATE OUR BENEFICIARY INFORMATION

Ensure that your beneficiaries are set up the way you want, especially if you haven't reviewed them in a while. Here's how:

- Log in to
- Click Profile
- Select Beneficiaries and follow the instructions

TAKE ADVANTAGE OF EDUCATIONAL RESOURCES

Attend an online workshop—Learn about a variety of topics.

Create a plan for your future—Model and plan for your financial goals using the Planning & Guidance Center at **Netbenefits.fidelity.com/planningcenter**.

Legally Required Notices

Women's Health and Cancer Rights Act Required Annual Notice

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to cover reconstructive surgery and prostheses following mastectomies. All medical plans provide this coverage.

If you receive benefits for a medically necessary mastectomy, and if you elect breast reconstruction after the mastectomy, you will also be covered for:

- 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 all stages of mastectomy including lymphedema.

HIPAA Notice of Special Enrollment Rights

Loss of Other Coverage

If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may in the future be able to enroll yourself and/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 dependent's coverage. To be eligible for this special enrollment opportunity, you must request enrollment within 30 days after your other coverage ends or after the employer stops contributing towards the other coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent(s). To be eligible for this special enrollment opportunity, you must request enrollment within 30 days after the marriage and within 30 days after the birth, adoption or placement for adoption.

Termination of Medicaid or SCHIP Coverage or Eligibility for Premium Assistance under Medicaid or SCHIP

If you or your dependent is eligible, but not enrolled for coverage, you may be able to enroll yourself and/or your dependent if either of the following events occur: (1) you or your dependent is covered under a Medicaid plan or under a State child health insurance plan (SCHIP) and coverage under the plan is terminated as a result of loss of eligibility; or (2) you or your dependent become eligible for premium assistance under Medicaid or SCHIP. To be eligible for this special enrollment opportunity, you must request enrollment within 60 days after the date you or your dependent become eligible for premium assistance or you or your dependent's Medicaid or SCHIP coverage ends.

HIPAA Privacy Notice

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information as mandated for health plans that are subject to HIPAA. Please review it carefully.

Name of Health Plan: CRH Americas Healthcare Plan (the "Plan")

The Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) requires certain health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information (45 Code of Federal Regulations parts 160 and 164). Where HIPAA applies to a health plan sponsored by the Employer, this document is intended to satisfy HIPAA's notice requirement for all health information created, transmitted, received, or maintained by the Plan. The regulations will supersede any discrepancy between the information in this notice and the regulations.

The Plan may create, transmit, receive, and maintain records that contain health information about you to administer the Plan and to provide you with healthcare benefits. This notice describes the Plan's health information privacy policy for your **healthcare, dental, vision, health reimbursement account and flexible spending account benefits.** The notice tells you the ways the Plan may use and disclose health information about you, describes your rights, and the obligations the Plan has regarding the use and disclosure of your health information. It does not address the health information policies or practices of your healthcare providers.

Our Commitment Regarding Health Information Privacy

The privacy policy and practices of the Plan protect individually identifiable health information known as Protected Health Information (PHI). PHI is any information that (a) is individually identifiable (i.e., contains your name or other distinguishing information); (b) is created, transmitted, or maintained by the Plan, whether in oral, written or electronic form; and (c) relates to (i) your past, present, or future physical or mental health or condition; (ii) the provision of healthcare to you; or (iii) the past, present, or future payment for the provision of healthcare to you. Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by law.

Privacy Obligations of the Plan

The Plan is required by law to: (a) make sure that health information that identifies you is kept private; (b) give you this notice of the Plan's legal duties and privacy practices regarding your PHI; and (c) follow the terms of the notice that is currently in effect.

How the Plan May Use and Disclose Health Information About You

The following are the different ways the Plan may use and disclose your PHI without your written authorization:

For Treatment. The Plan may use or disclose your PHI in connection with your medical treatment. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment. The Plan may use and disclose your PHI in connection with obtaining or arranging payment for your healthcare. This includes, but is not limited to, making coverage determinations and administering tasks such as billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, utilization review and pre-authorizations. For example, the Plan may receive and maintain information about surgery you received to enable the Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

For Healthcare Operations. The Plan may use and disclose your PHI in connection with the administration of healthcare under the Plan. For example, the Plan may use your PHI for case management or to perform population-based studies designed to reduce healthcare costs. In addition, the Plan may use or disclose your PHI for healthcare operations including, but not limited to, quality assessment and improvement, reviewing competence or qualifications of healthcare professionals, activities relating to creating or renewing insurance contracts, and other administrative activities necessary to operate the Plan.

To the Plan Sponsor. The Plan may disclose your PHI to CRH Americas in certain circumstances. First, the Plan may disclose enrollment information to CRH Americas. Second, the Plan may disclose summary health information to CRH Americas so that CRH Americas can obtain premium bids or modify, amend, or terminate the Plan. Third, the Plan may disclose PHI to CRH Americas to perform Plan administrative functions and CRH Americas will not further use or disclose that PHI except as permitted or required by

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For Payment. The Plan may use and disclose your PHI in connection with obtaining or arranging payment for your healthcare. This includes, but is not limited to, making coverage determinations and administering tasks such as billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, utilization review and pre-authorizations. For example, the Plan may receive and maintain information about surgery you received to enable the Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

For Healthcare Operations. The Plan may use and disclose your PHI in connection with the administration of healthcare under the Plan. For example, the Plan may use your PHI for case management or to perform population-based studies designed to reduce healthcare costs. In addition, the Plan may use or disclose your PHI for healthcare operations including, but not limited to, quality assessment and improvement, reviewing competence or qualifications of healthcare professionals, activities relating to creating or renewing insurance contracts, and other administrative activities necessary to operate the Plan.

To the Plan Sponsor. The Plan may disclose your PHI to CRH Americas in certain circumstances. First, the Plan may disclose enrollment information to CRH Americas. Second, the Plan may disclose summary health information to CRH Americas so that CRH Americas can obtain premium bids or modify, amend, or terminate the Plan. Third, the Plan may disclose PHI to CRH Americas to perform Plan administrative functions and CRH Americas will not further use or disclose that PHI except as permitted or required by

the Plan documents and by law. Only employees involved in the administration of the Plan will have access to your PHI to perform Plan administrative functions, including (but not limited to) enrollment, payroll deductions, evaluating potential new insurers or service providers to the Plan, assisting participants with claims disputes and questions, and coordinating COBRA continuation coverage.

Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process, but if the requesting party is not the court, the requesting party must have made a good faith attempt to inform you of the proceeding and permit you to raise an objection or obtain an order protecting the information requested.

Law Enforcement. The Plan may release your PHI when required or permitted by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.

Workers Compensation. The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws and other similar programs established by law.

Military and Veterans. If you are or become a member of the U.S. armed forces, the Plan may release medical information about you as deemed necessary by military command authorities.

To Avert Serious Threat to Health or Safety. The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Public Health Risks. The Plan may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products.

Health Oversight Activities. The Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the healthcare system and government programs.

Research. Under certain circumstances, the Plan may use and disclose your PHI for medical research purposes (subject to approval by institutional or private privacy review boards and subject to other certain conditions).

National Security, Intelligence Activities, and Protective Services. The Plan may release your PHI to authorized Federal officials: 1) for intelligence, counter-intelligence, and other national security activities authorized by law and 2) to enable them to provide protection to the members of the U. S. Government or foreign heads of state (only in compliance with U.S. law), or to conduct special investigations.

Organ and Tissue Donation. If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funeral Directors. The Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plan may also release your PHI to a funeral director, as necessary, to carry out his or her duty.

Other Uses and Disclosures of Health Information

A plan must obtain your written authorization to use or disclose psychotherapy notes, to use PHI for marketing purposes, or to sell PHI. However, the following types of communications are not considered marketing: (i) Treatment Alternatives (the Plan may use and disclose your PHI to inform you of possible treatment options or alternatives that may be of interest to you.); or (ii) Health-Related Benefits and Services (the Plan may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.)

Plans (excluding long-term care plans) are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plan will be made only with your written authorization. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the Plan will not reverse any uses or disclosures already made in reliance on the authorization before the Plan Administrator received your written notice revoking your authorization.

Minimum Necessary Standard

The Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request. The “minimum necessary” standard will not apply, however, to certain disclosures of your PHI to you.

Your Rights Regarding Health Information About You

Your rights regarding the health information the Plan maintains about you are as follows:

Right to Inspect and Copy. You have the right to inspect and receive a copy of your PHI that is used to make decisions about your treatment or payment for your care. For PHI that you have a right to access, you have the right to receive your PHI in an electronic format if it is readily producible in such format, and to direct the Plan to transmit a copy of your PHI to an entity or person you designate, provided the designation is clear, conspicuous and specific. To inspect and copy health information maintained by the Plan, submit your request in writing to the Privacy Officer. The Plan may charge a fee for the cost of copying, mailing or for other supplies associated with your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you feel that PHI the Plan has about you is incorrect or incomplete, you may ask to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, send a detailed request in writing to the Privacy Officer. You must provide the reason(s) to support your request. If your request is denied, the Plan will provide you with an explanation of the reason for the denial. The Plan may deny your request if you ask the Plan to amend health information that (i) is already accurate and complete; (ii) was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment; (iii) is not part of the health information kept by or for the Plan; or (iv) is not information that you would be permitted to inspect and copy. If the Plan denies your request for an amendment, you have the right to file a statement of disagreement with the Plan and any future disclosures of the disputed information will include your statement of disagreement.

Right to an Accounting of Disclosures. You have the right to request an “accounting of certain disclosures.” This is a list of disclosures of your PHI that the Plan has made to others, except for (i) those necessary to carry out treatment, payment, or healthcare operations; (ii) disclosures made to you; (iii) disclosures made to friends or family members in your presence or because of an emergency; (iv) disclosures made for national security purposes; or (v) disclosures that were incidental to otherwise permissible disclosures. To request an accounting of disclosures, submit your request in writing to the Privacy Officer. Your request must

state a time period, which may not be longer than six years prior to the date the accounting was requested nor start more than six years before the date of your request. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. Additional lists will be subject to reasonable charge.

Right to Request Restrictions. You have the right to request that the Plan limit the PHI the Plan uses or discloses about you for treatment, payment, or healthcare operations. You also have the right to request a limit to your PHI that the Plan discloses about you to someone who is involved in your care or the payment for your care, (i.e., a family member or friend). For example, you could ask that the Plan not use or disclose information about a surgery you had. To request restrictions, make your request in writing to the Privacy Officer. You must advise us: 1) what information you want to limit; 2) whether you want to limit the Plan's use, disclosure, or both; and 3) to whom you want the limit(s) to apply (for example, your spouse). Note: The Plan is not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about your PHI in a certain way or at a certain location if you would be endangered by the usual method of communication.. For example, you can ask that the Plan send you explanation of benefits (EOB) forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to the Privacy Officer. The Plan will make every attempt to accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your PHI could endanger you. You do not have to provide the specific reason that you believe the disclosure of your PHI could endanger you. Your request must specify how or where you wish to be contacted.

Right to Opt Out of Fundraising Communications. While the Plan has no intention of being involved in fundraising activities, if the Plan intends to contact you to raise funds for the Plan, you have the right to opt out of receiving such communications.

Right to a Paper Copy of this Notice. You have the right to receive a paper copy of this notice. You may write to the Privacy Officer to request a written copy of this notice at any time. This notice will also be posted on the Plan Sponsor's website.

Right to Receive Notification of a Breach of Unsecured PHI. You have a right to receive a notice if there is a breach of your unsecured PHI (i.e., your PHI is disclosed in violation of HIPAA and there is more than a low probability that the PHI has been compromised). If it is determined from the Plan's risk assessment that a breach has occurred, you will be notified without unreasonable delay and no later than 60 days after discovery of the breach. The notification will include information about what happened and what may be done to mitigate any harm.

A Note About Personal Representatives

You may exercise your rights through a personal authorized representative. Your personal representative will be required to produce evidence of his or 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. Proof of such authority may take one of the following forms:

- A healthcare power of attorney , notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual;
- A designation of a personal representative; or
- An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative if the Plan has a reasonable belief that (1) you have been or may be subjected to domestic violence, abuse or neglect by such person; (2) treating such person as your personal representative could endanger you; or (3) it is not in your best interest to treat the person as your personal representative. This also applies to personal representatives of minors.

Changes to this Notice

The Plan reserves the right to change the terms of this Notice of Privacy Practices and to the Plan's privacy policies from time to time. If the Plan makes a change, the Plan will (i) post its revised Notice on the Plan Sponsor's benefits website and distribute the revised version of this Notice or information about the material change to affected individuals in the next annual mailing to participants, or (ii) provide its revised notice, or information about the material change and how to obtain the revised notice within 60 days of the material revision to the notice to those affected individuals who do not have access to the benefits website.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Privacy Officer at the address listed below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services by submitting a detailed written description of the issue to your regional Office for Civil Rights. Your description must name the covered entity (the Plan) and what action (or lack of action) you believe has violated HIPAA. Your complaint must be submitted within 180 days of when you knew or should have known of the issue, unless this deadline is waived by the Office of Civil Rights. You can find the address for your regional office at **http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html.** Note: You will not be penalized or retaliated against you for filing a complaint.

Contact Information: If you have any questions about this notice, please contact the Privacy Officer at
CRH Americas
Attn: HIPAA Privacy Officer,
900 Ashwood Parkway
Atlanta, GA 30338

Updated and effective September 23, 2023.

Marketplace Notice
New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

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.[1]

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 CRH Americas Benefit Help Line at **888.437.4866**.

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.

[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.

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.

CRH Americas, Inc.	95-3298140	
900 Ashwood Parkway, Suite 600	888.437.4866	
Atlanta	GA	30338
CRH Americas Benefit Help Line		
888.437.4866		

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:

☑ Some employees. Eligible employees are:
Full-time, non-union employees of CRH (or union employees eligible to receive these benefits, pursuant to a collective bargaining agreement) are eligible to participate in the company's benefit programs. If you participate in a union-sponsored plan, you will need to contact your union representative for specific plan and eligibility information.

» With respect to dependents:

☑ We do offer coverage. Eligible dependents are:
Your legal spouse, children up to age 26, stepchildren who you support financially and/or who live with you in a parent/child relationship, child(ren) placed in your home for adoption or for whom you are the legal guardian or are required to provide coverage for, and dependents totally and permanently disabled before the age of 19.

☐ We do not offer coverage.

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

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

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

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 **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 **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
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/ health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid. georgia.gov/programs/third-party-liability/ childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.967.4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/ benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/ applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 711| Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health- care-programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178

NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 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
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2026)

Important Notice from CRH Americas, Inc. 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 CRH Americas, Inc. and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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. CRH Americas, Inc. has determined that the prescription drug coverage offered by the CRH Americas Healthcare Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 through December 7. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. If you do decide to enroll in a Medicare prescription drug plan and drop your CRH Americas, Inc. prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with CRH Americas, Inc. and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

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

Contact your Division office for further information. You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through CRH Americas, Inc. changes. You also may request a copy.

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 prescription drug plans.

For more information about Medicare prescription drug plans:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see your copy of the "*Medicare & You"* handbook for their telephone number) for personalized help,
- Call **800.MEDICARE (800.633.4227)**. TTY users should call **877.486.2048**.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you call them at **800.772.1213** (TTY **800.325.0778**).

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

Date:	October 1, 2023
Name of Entity/Sender:	CRH Americas, Inc.
Contact:	CRH Americas Healthcare Plan
Address:	900 Ashwood Parkway Atlanta, GA 30338

NOTE: THIS NOTICE DESCRIBES HOW YOUR GROUP HEALTH COVERAGE MAY BE CONTINUED FOLLOWING THE OCCURRENCE OF CERTAIN QUALIFYING EVENTS. PLEASE REVIEW IT CAREFULLY. THIS LETTER IS TO ADVISE YOU OF YOUR RIGHTS, ONLY. THIS IS NOT A LETTER OF TERMINATION. NO ACTION IS NECESSARY ON YOUR PART.

Introduction

It is important that all covered individuals (employee, spouse, and dependent children) take the time to read this notice carefully and be familiar with its contents. You are receiving this notice because you have recently become covered under your employer's group health plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

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

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

If the Plan provides healthcare coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

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

employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitle to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **www.dol.gov/ebsa.** (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Employer Informed of Address Changes

In order to protect your family's rights, you should keep COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to COBRA Administrator.

Plan Contact Information

If you do not understand any part of this summary notice or have questions regarding the information or your obligations, please contact us by phone at **888.437.4866** or submit a written request to:

Businessolver
Attn: COBRA Administrator
P.O. Box 310512
Des Moines, IA 50331-0512

Important Benefit Disclosures Under ERISA

Dear Participants in the CRH Americas, Inc. Health and Welfare Benefit Plans:

As a Participant in the CRH Americas, Inc. Health and Welfare Benefits and 401(k) Plans, you are entitled to receive certain information about our benefits as required by the Employee Retirement Income Security Act of 1974 (ERISA). CRH Americas, Inc. intends to provide this information to you by electronic delivery. Included are the following:

- **Summary Plan Descriptions – Health and Welfare Plans**
- **Summary Plan Description – CRH Americas 401(k) Plan**
- **Summaries of Material Modification**
- **Summaries of Benefits and Coverage**
- **Summary Annual Report – Health and Welfare Plans**
- **Summary Annual Report – CRH Americas 401(k) Plan**
- **Initial COBRA Notification**
- **Annual Notices**
- **Marketplace Notice**

To access these documents, please visit our benefits website at **www.benefitsolver.com** and login in using your User Name and Password. If you have questions about registering for the site or how to log in, please contact the **CRH Americas Benefits Helpline at 888.437.4866**.

The documents listed above may be found on the website in the **Benefit Library under Legal Notices.**

If you cannot access these documents via the website, please contact the **CRH Americas Benefits Helpline**, by mail at **1025 Ashworth Road, Suite 101, West Des Moines, IA 50265,** or by phone at **888.437.4866.**

NOTE: If any of these requirements or delivery methods change in a way that creates a material risk that you may no longer be able to access and retain electronically transmitted documents, we will furnish you with notice and a request that you provide a new consent.

You have a right to receive a paper version of any electronically transmitted document at no charge. Please contact the **CRH Americas Benefits Helpline,** by mail at **1025 Ashworth Road, Suite 101, West Des Moines, IA 50265,** or by phone at **888.437.4866** to obtain a paper copy.

You may withdraw this consent at any time by notifying the **CRH Americas Benefits Helpline** in writing, by mail at **1025 Ashworth Road, Suite 101, West Des Moines, IA 50265,** with “Consent Withdrawn for Electronic Disclosure” in the subject line. Include your full name, address, and phone number in the body.

Para obtener información sobre la inscripción anual de plan de salud en español, comuníquese con su departamento local de Recursos Humanos/Beneficios.

Notes

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

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