Benefits for Everywhere You Live, Work & Play

Employee Benefits Guide 2025

Employee Name: _____

Benefit Effective Date: _____

Enroll by Date: _____

For Enrollment instructions, refer to page 3

What's Inside

Scan the QR code to view our Benefits Enrollment video.

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.

Enroll in Your Benefits

1 Login Online

Visit **www.benefitsolver.com** If it's your first time, use the case-sensitive company key **OLDCASTLE** to set register. If you've been here before but forgot your login details, click the *Forgot your username or password?* link to reset your login details.

2 Setting Up the MyChoice App

Scan the QR code to the right for your device's operating system (iOS for Apple or Android). Type in your phone number with area code to text a link that will download the Mobile App directly to your phone. Use the 6-digit Access Code to activate the Mobile App. Answer the security questions and provide multi-factor authentication.

3 Starting Your Enrollment

- **Online:** Click the Start Here button to review your personal information and add or edit any dependents. Use the Next and Back buttons to review your options.
- **Via the App:** New Tasks will alert you when the enrollment opportunity is available. Click the Start Enrollment button to enter and review your personal information and add or edit any dependents you wish to cover.

4 Making Your Enrollment Decisions

If you'd like some help deciding on which benefits to elect, try the **MyChoice Recommendation Engine.** Answer a few questions to receive a confidential, personalized benefits recommendation. Choose or decline coverage for each option and select which family members you want to cover. Provide each dependent's legal name, Social Security number and birth date. You will be required to provide supporting documentation to prove your relationship to each dependent.

5 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. Return to the Dashboard after you enroll to check for any additional tasks you need to complete.

Questions?

- Call **888-437-4866** Mon – Fri 8 a.m. – 5 p.m. CST.
- **Open Enrollment Extended Hours:**
  Monday-Friday 7 a.m. – 7 p.m. CST;
  Saturday 8 a.m.-2 p.m. CST
- Visit: **www.benefitsolver.com**. Use company key: **OLDCASTLE**

Action is required to enroll, change or waive coverage.

Benefits Overview

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.

One Premium Covers Your Healthcare

We're proud to offer a healthcare package for you and your family which bundles medical, pharmacy, Employee Assistance Program (EAP), dental and vision together under one premium. Choose from a PPO Plan and HSA Plan with the UMR UnitedHealthcare Choice Plus Network.

Teladoc for Healthcare Anywhere, Anytime

Medical plan members can see a doctor through video chat on their computer or mobile device. PPO Plan members pay a $10 copay and HSA Plan members pay deductible/coinsurance.

Employee Assistance Program (EAP)

Employees and their family members can access services 24/7 including face-to-face counseling, emotional well-being, legal and financial services, ID recovery and child/elder care resources.

Spending Accounts to Save You Money

CRH Americas provides the Health Savings Account, as well as the Health Care and Dependent Day Care Flexible Spending Accounts that let you pay for eligible expenses with tax-free dollars.

Life & Disability Income Protection

In case you become injured, ill, or worse, we offer financial protection for you and your family through company-paid Basic Life/AD&D and Disability coverage. You can purchase additional life coverage for yourself, your spouse and dependent children. And, other state-based leave programs and/or company pay-for- time-not-worked may apply.

Saving for Tomorrow with Your 401(k)

Set money aside for your future by contributing to a retirement account through traditional pre-tax or Roth post-tax contributions. CRH Americas provides a matching contribution of up to 5%.

Vendor Contact Information

You may contact any of the CRH Americas benefit providers regarding specific plan questions.

Benefit Type	Vendor	Assistance Provided for
Enrollment & Eligibility benefitsolver	BenefitSolver 888-437-4866 www.benefitsolver.com Company Code: OLDCASTLE	❖ Benefit enrollment ❖ Verification of eligibility and coverage ❖ COBRA support or questions
HealthEquity HealthEquity	HealthEquity 866-346-5800 www.my.healthequity.com www.learn.healthequity.com/crh	❖ HealthEquity Spending Accounts: • Health Savings Account (HSA) • Health Care FSA • HSA-Compatible Health Care FSA • Dependent Care FSA (DCFSA)
Medical UMR	UMR Policy #: 76-416276 800-826-9781 (General) 800-207-3172 (Dedicated) www.umr.com	❖ Combined medical & prescription ID cards ❖ Find a medical care provider ❖ Pre-certification/pre-authorization ❖ Coordination of benefits ❖ Medical claims details and issues ❖ EOB (Explanation of Benefits) statement
Prescription Drugs CVS caremark	CVS Caremark Policy #: 364149 800-378-0458 www.caremark.com	❖ ID Card combined with medical card ❖ Find a pharmacy ❖ Prescription drug formulary ❖ Retail 90-day refills ❖ Home delivery (mail order) ❖ CVS Specialty Drugs • 866-846-3095 / www.cvsspecialty.com
Dental DELTA DENTAL	Delta Dental Policy #: 16112 800-521-2651 www.deltadentalins.com	❖ Dental ID cards ❖ Find a dental care provider ❖ Dental coverage details & claims status ❖ Assistance with dental claims issues
Vision EyeMed	EyeMed Policy #: 9801226/9800996 866-723-0513 www.eyemedvisioncare.com	❖ Vision ID cards ❖ Find a vision care provider ❖ Vision coverage details & claims status
Virtual Healthcare Teladoc HEALTH	Teladoc 1-800-835-2362 www.teladoc.com	❖ Virtual primary, dermatology, and mental healthcare ❖ 24/7 video doctor visit to discuss common health conditions ❖ Counseling services
Life/Disability/ Leave Claims unum	UNUM Policy #: 952620 Life and AD&D Policy #: 468683 001 STD Policy #: 469768 001 LTD 866-215-1720 www.unum.com	❖ File a new leave of absence or disability claim ❖ Life and/or disability status ❖ Report intermittent FMLA hours during leave of absence ❖ To request portability/conversion paperwork: • 866-220-8460
Employee Assistance Program (EAP) Optum	Optum Policy #: 2134598 Company code: CRH 866-248-4096 www.liveandworkwell.com/en/public	❖ Confidential referral for various services: • Face-to-face counseling • Mental health • Legal and financial services • ID recovery
Retirement – 401k Fidelity	Fidelity Policy #20822 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

Welcome

CRH offers a variety of benefit options so you can choose the type of coverage, protection, and investments that work for you and your family.

- CRH Americas Healthcare Benefits: Medical, Pharmacy, Dental, and Vision
- Tax-Free Spending Accounts: Health Flexible Spending (FSA) & Dependent Care Flexible Spending (DCFSA)
- Life & Disability Insurance
- 401(k) Retirement Savings

Take some time to read about your options. **The elections you make are in effect for the benefit plan year,** so be sure that the choices you make during your initial enrollment and Annual Open Enrollment will work for you and your family all year long (and/or for the remaining eligible months of coverage during the plan year). Thanks for being a part of the team at CRH Americas!

What's New for 2025?

Health Insurance (bundled medical, pharmacy, dental, AND vision) Changes:

- **NO premium increase** in 2025 for employees
- The High Deductible Health Plan will be referred to as the "HSA Plan" going forward.
- Due to IRS requirements, the HSA Plan in-network deductibles are increasing $100 to $3,300/individual and $200 to $6,600/family.

Vendor Change for the Consumer Accounts (FSA & HSA):

- HealthEquity will be replacing MyChoice Accounts administration effective January 1, 2025.
- CIP will be reprocessed under HealthEquity. (Please verify name, DOB, and SSN are correct in Benefitsolver.)
- A bulk transfer of HSA balances from UMB to HealthEquity at no cost will be offered to HSA participants during Annual Open Enrollment. You must complete e-consent by December 30, 2024.

Benefits Eligibility

You are eligible for CRH Americas benefits if you are an active employee and are:

- Full-time and regularly scheduled to work an average of 30 hours per week
- Working and earning income in the U.S.
- Non-union or union employees that are eligible for benefits under a collective bargaining agreement

You may add eligible dependents to your CRH Americas plan. Eligible dependents are:

- Your legal spouse
- Children, stepchildren, adopted child, or any other child you are the legal guardian of up to the end of the month of their 26th birthday
- Dependents totally and permanently disabled before age 19 – subject to verification

Domestic partners and common law marriage partners are not eligible for coverage under the plan.

Eligible spouses/dependents who work for CRH Americas may enroll as a participant on their own separate plan or be covered as an enrolled dependent (spouse or child) of the other, but not both.

Please refer to the **Dependent Verification page** of this guide for additional information.

Enrolling in Your Benefits

New Hire Enrollment

As a new hire, you are eligible to enroll the first of the month following 60 days of continuous employment. After your enrollment period has closed, you will **NOT** have the opportunity to enroll unless you experience a qualifying life event or until the next Annual Open Enrollment.

Annual Open Enrollment

Each year in mid-October through mid-November, you may add, delete, or make changes to your benefit elections for the upcoming plan year.

2025 Annual Open Enrollment

Enrollment Dates: October 14 – November 5, 2024
Benefits Begin: January 1, 2025

2026 Annual Open Enrollment

Enrollment Dates: October 13 – November 4, 2025
Benefits Begin: January 1, 2026

REQUIRED FOR OPEN ENROLLMENT:

You **MUST** enroll in a Healthcare Plan or waive coverage.

Your choices are the **PPO Plan** or **HSA Plan**

(both Healthcare Plans include Medical, Pharmacy, Dental and Vision).

Breaks in Service

CRH Americas is a large building materials business comprising of multiple divisions and companies (Oldcastle APG, Oldcastle Infrastructure, Americas Materials, Americas Cement, and their related companies). Rehired and transferred employees may find their benefit enrollment window expedited depending on their break in service with the company. Please notify HR if you have previously worked for a CRH Americas company.

When Coverage Ends

If you are no longer eligible for benefits or you leave CRH Americas, coverage will end the last day of the month when your classification changes and/or your job is terminated.

If you're rehired, transferred, or return to work after break in service...		
30 days or less	Your elections will be reinstated with no lapse in coverage.	If initial eligibility is not met and there is a break in service, the time from the initial hire date will count towards your eligibility.
31 – 180 days	You are eligible for coverage day 1 of the month following your rehire.	You must enroll to gain coverage.
180+ days	You are eligible for coverage day 1 of the month following 60 days of your employment.	

Qualifying Life Events

Certain benefit plans allow limited changes during the plan year including medical, dental, vision, optional life insurance and Flexible Spending Accounts. For these benefits, you may change your elections during the plan year if you have a change in family status. This is called a Qualifying Life Event and includes, but isn't limited to:

- 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
- Obtaining other coverage
- HIPAA Special Enrollment, Court Judgment or Decree
- Medicare or Medicaid enrollment, or loss of coverage

Coverage for Newborns

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 or your child will not be covered.

Changing Your Elections

You must notify Benefitsolver of any Qualifying Life Event as soon as possible, but no later than 60 days from the date of the event. **If notification of a Qualifying Life Event isn't made within 60 days from the date of the event, you can't make any changes until the next Annual Open Enrollment.**

Go online to **www.benefitsolver.com** or call the CRH Americas Benefits Helpline at **888-437-4866** to make the change and provide the required documentation. Adding a dependent may require dependent verification. **Discontinuing coverage for a dependent may become a Qualifying Life Event that allows them to be covered under COBRA.**

Divorce

Once a divorce is finalized, your ex-spouse (and related stepchildren) are no longer eligible dependents. Ineligible dependents cannot stay on the CRH Americas employer sponsored health plan. An employer is required to offer COBRA coverage to an ex-spouse, but only if Businessolver is notified within 60 days of the date the divorce is finalized. If you do not give Businessolver proper notice, the ex-spouse will not be offered COBRA coverage. If an employee is required by a divorce decree or court document to provide health insurance coverage on an ex-spouse, this requires action on the employee's part to provide health insurance coverage — it does not obligate the employer to keep the ex-spouse on the employer-sponsored health plan.

Dependent Verification Guidelines

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 Annual Open Enrollment), you will be asked to provide documentation to verify your dependent's eligibility. Failure to provide the correct 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 by the due date. This letter is also available in your personal documents on **www.benefitsolver.com**. Examples of required documentation include the following:

Spouse

- Photocopy of an official marriage certificate

Child

- Photocopy of a birth certificate or a 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
- 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 you.
- Adoption Certificate or Court Assignment of Guardianship form that is signed and/or stamped by a member of the court
- When adding a dependent, have their Social Security number and date of birth available.

Dependent Social Security Number Request

We are required to file an informational return with the IRS identifying employees and their dependents for whom we provide Minimum Essential Coverage (MEC). This information will confirm with the IRS that all identified individuals have satisfied their obligations under the Individual Mandate to maintain MEC and are therefore not subject to a penalty. During your enrollment process, you will be prompted to add your dependent's Social Security number(s).

Submit Documentation

- Timely submission of documents is required.
- Verification MUST be returned by the due date, or your dependents WILL NOT be covered.
- Do not mail original documents as they will not be returned.

Scan and Upload

Documentation that is scanned and uploaded is processed more efficiently.

- Login to **www.benefitsolver.com**.
- If you have forgotten your password, select the Trouble Logging In 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 by selecting the upload document option.

Email

dv@businessolver.com

Fax

877-769-8799

Mail

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

Register at Benefitsolver Before You Enroll

When you go online to enroll, you'll find lots of benefits information in the Reference Center, and the number of days left to enroll will be shown at the top of the Home page. Start by registering at Benefitsolver using one of these methods:

1. Visit **www.benefitsolver.com** and use the company code **OLDCASTLE** to register and create your username and password.

2. Download the **MyChoice app** by going directly to Google Play or Apple store and use the company code **OLDCASTLE** to register.

3. Call Benefitsolver at **888-437-4866** and speak to member services. **Please Note:** Calls are recorded.

Questions?

Call **888-437-4866** Monday to Friday, 8am-5pm CST or visit **www.benefitsolver.com** and use company key **OLDCASTLE.** **Extended hours for open enrollment are Monday to Friday 7am-7pm and Saturday 8am-2pm CST.**

Action is required to enroll, change, or stop coverage.

Review and Choose Your Options

- **Decision Support Tool:** Answer a few simple questions to receive a personalized confidential benefits recommendation and then you can enroll.
- **Explore On Your Own:** Use the Next and Back buttons to review and choose options. Review plan documents and use Compare and Plan 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.
- **Gather Dependent Information:** 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.
- **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 ensure no additional tasks are required to finalize your enrollment.

Health & Welfare

CRH Americas benefits help you maintain your medical, dental and vision health. Our medical plans protect you financially, limiting your out-of-pocket costs for necessary medical care due to illness or injury. **CRH Americas pays the majority of the cost for your benefits.** You also have the opportunity to earn valuable reductions in payroll contributions for participating in our Wellness Initiative.

Beyond your physical health, we want you to be healthy in all aspects of your life. As you prepare for your initial or Annual Open Enrollment, we encourage you to review this benefit guide in order to take full advantage of all that is offered to you as an employee of CRH Americas.

Where to Go for Healthcare

When you aren't feeling well, it's difficult to decide where to go for help. Should you request a Virtual Visit, call your Primary Care Physician (PCP), go to Urgent Care, or visit the Emergency Room (ER)?

Virtual Visits Available through Teladoc

Teladoc Health gives you 24/7 access to U.S. board certified doctors through the convenience of your phone for your copay or coinsurance subject to your deductible. Visit **TeladocHealth.com**, call **800.835.2362**, or download the app.

Your Primary Care Physician (PCP)

If you believe your condition is not life-threatening, you may want to set up an in-person appointment with your PCP. They can treat you based on knowledge of your medical history for your copay or coinsurance subject to your deductible.

If You Can't Wait, Consider Urgent Care

Urgent care centers are usually open evenings, weekends, and holidays with extended hours. Many offer fast, easy online scheduling, in addition to walk-in and call-ahead options.

When is a trip to the ER the right choice?

If your instincts tell you that your condition is life-threatening, call 911 or go to the closest Emergency Room. Symptoms that require immediate attention include, but are not limited to:

- Shortness of breath
- Severe trauma or bleeding
- Severe abdominal pain
- Drug overdose/accidental poisonings
- Chest pain
- Symptoms of a stroke (facial drooping, arm/leg weakness or paralysis, speech difficulty)

Keep in mind that the ER is designed to treat patients with critical conditions and life-threatening injuries. The average wait time can be four to five hours, or longer, if your condition is not serious.

2025 Employee Contributions

The majority of your benefit costs are covered by CRH Americas. Employee's portion of the premium is based on the coverage tier election. As the cost of living continues to rise, our employees are facing increasing expenses for housing, transportation, food, utilities, and taxes. Healthcare costs are no exception to this trend. However, CRH Americas recognizes the burden of these increases shouldn't be passed on to our employees. Looking ahead to 2025, we are pleased to announce that there will be **no increase in your portion of health insurance premiums.** This is yet another demonstration of our commitment to valuing our employees.

CRH Americas Employee Contributions
All contributions include medical, pharmacy, dental and vision benefits

PPO Plan
(Excludes Wellness Credit and Spousal Surcharge)

Coverage for	Annual Rate	Monthly Rate
Employee Only	$2,040	$170
Employee + Spouse	$4,200	$350
Employee + Child(ren)	$3,660	$305
Family	$5,880	$490

HSA Plan Rates
(Excludes Wellness Credit and Spousal Surcharge)

Coverage for	Annual Rate	Monthly Rate
Employee Only	$1,128	$94
Employee + Spouse	$2,220	$185
Employee + Child(ren)	$1,944	$162
Family	$2,940	$245

The contribution rates listed above are annual and monthly rates and are withheld on a pre-tax basis from your payroll. Your payroll deductions may vary based on your company-specific payroll frequency and any deduction, credits and surcharges that may apply such as the Spousal Surcharge or Wellness Credit. Because these contributions are collected on a pre-tax basis, the IRS restricts changes to initial or Annual Open Enrollment or within 60 days of a Qualified Life Event.

Spousal Surcharge

If your spouse is eligible for their employer's medical coverage or is covered by another qualified plan and then enrolls in the CRH Americas Health Plan, you will be responsible for paying the spousal surcharge of **$225** per month for the PPO plan or **$175** per month for the HSA plan.

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

Waiving the Spousal Surcharge

You will not be subject to the Spouse Surcharge if:

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

If any of the above apply, then the Surcharge does not pertain to you. However, the Spousal Surcharge Waiver must be completed. Go online to **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 offers a Wellness Credit to you to help promote health and wellness. You and your spouse (if enrolled in the CRH Americas Health Plan) are eligible to participate and receive a $25 per person per month reduction in your health plan premiums (up to $50 a month). An age-appropriate physical exam must be completed with your in-network provider to earn the Wellness Credit.

- If you complete the physical exam but your covered spouse does not, the credit is $25 per month.
- If both you and your covered spouse complete the physical exam, the credit is $50 per month.
- If your spouse completes the initiative, but you do not, no credit will be awarded. You must complete the exam in order for your spouse to receive a Wellness Credit.

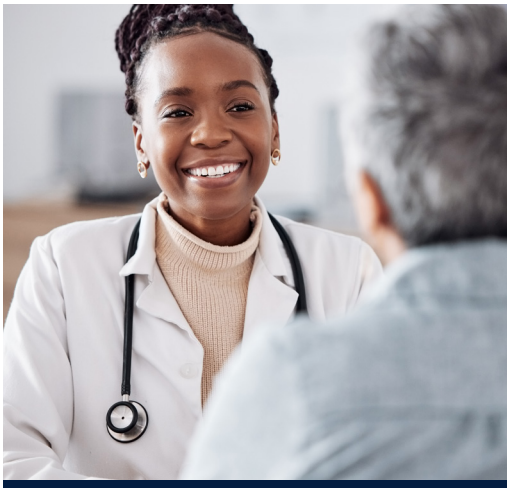
Your doctor will determine what should be included in your age-appropriate physical exam such as:

- Blood panel: Cholesterol level with both LDL and HDL
- Glucose level (for non-diabetics)
- A1c level (for diabetics)
- Blood pressure
- Mammogram & Pap Smear
- Colorectal Screening

UMR will verify the completion of physical exams based on the claim(s) filed by your doctor. You can check for verification in your account at **www.benefitsolver.com**.

- Log in and look for 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 for the Wellness Credit Employee.
- If your spouse has completed the wellness initiative, you will see Yes for the Wellness Credit Spouse.
- You will see the total amount of your eligible credit as Wellness Rollup located at the top of the tracker.

Allow for lags in timely claim submissions by providers. If you don't see your credit shortly after your wellness visit, check back periodically to see if the update has been received.



2025 Wellness Credit

The Wellness Credit to reduce your health plan premiums in 2025 applies to you and your covered spouse if your physical exams were completed between September 1, 2023, and August 31, 2024.

If you and your spouse were added to the health plan July 1, 2024, through August 31, 2024, completion of physical exams will not be required to receive the contribution reduction in 2025.

2026 Wellness Credit

The Wellness Credit to reduce your medical plan premium in 2026 applies to you and your covered spouse if your physical exams are completed between September 1, 2024, and August 31, 2025.

If you and your spouse are enrolled in the health plan between July 1, 2025 through August 31st, 2025, completion of the physical exam will not be required to receive the contribution reduction in 2026.

Medical Plans | UMR

We offer two health insurance options with the UnitedHealthcare Choice Plus network so that you can choose the right fit for your healthcare needs and your budget.

- PPO Plan
- HSA Plan

How PPO and HSA Medical Plans Differ

Qualified High Deductible Health Plans have lower premiums and higher deductibles but allow you to save pre-tax funds in a Health Savings Account (HSA) and use them to pay for eligible medical expenses. A PPO offers lower deductibles but has higher premiums, and copays. To choose between them, compare the costs and benefits of each plan and estimate your healthcare needs and expenses.

When Pre-Certification is Needed

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 of procedures is available at **www.umr.com** and **www.benefitsolver.com**. To pre-certify a procedure call **800-207-3172**.

Services the CRH Americas Medical Plan does NOT Cover

(This is not a complete list. Check plan documents for other excluded services.)

- Bariatric surgery and complications
- Weight loss programs
- Cosmetic surgery
- Surgery and services for gender reassignment
- Dependent daughter maternity
- Hearing Aids (see discount available through EyeMed)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care

Understanding Medical Insurance 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 out-of-network provider charges more than the allowed amount, you may have to pay the difference.
- **Balance Billing:** When an out-of-network healthcare provider charges a higher price than the amount your insurance agreed to pay, and you are billed for 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 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 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 must pay first out-of-pocket before your health plan begins to pay (excluding copays under the PPO Plan). For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 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 plan has contracted with to provide healthcare services.
- **Out-of-Network:** The facilities, providers and suppliers your health 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 plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges, penalties for noncompliance, and healthcare that the health plan doesn't cover.
- **Primary Care Physician:** A physician who 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.

Your Medical Plan Options

CRH Americas Medical Options				
Plan Benefits	**PPO Plan**		**HSA Plan**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible*	$1,000 Individual / $3,000 Family	$2,000 Individual / $6,000 Family	$3,300 Individual / $6,600 Family	$6,600 Individual / $13,200 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
Health Savings Account (HSA) Contribution from CRH	N/A		**Employee:** $500; **Employee +1:** $750 **Employee + 2 or more:** $1,000; **Family:** $1,000	
Lifetime Maximum/ participant	Unlimited			
Coinsurance is shown as Member Responsibility / Plan Responsibility				
Inpatient Hospital Services Penalty if you don't pre-certify	20% / 80% Coinsurance $250	40% / 60% Coinsurance $250	20% / 80% Coinsurance $250	40% / 60% Coinsurance $250
Emergency Room/Emergency Treatment (accident and medical emergency situation within 48 hours)				
Facility Charges	Plan pays 80% after $150 member copay; deductible waived		20% / 80%	
Physician Charges				
Urgent Care	$25 copay			
Non Emergency				
Facility Charges	20% / 80%	40% / 60%	40% / 60%	40% / 60%
Physician Charges				
Medical/Surgical Services				
Office Visit	$25 PCP copay; $40 specialist copay	40% / 60%	20% / 80%	40% / 60%
Online Visit through Teladoc (doctor, therapist or psychologist)	$10 copay	N/A	20% / 80%	N/A
Physician Surgical Services Inpatient / 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			
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 Pre-certification required after 18 visits				

Embedded Deductible: If you have family coverage, each family member is only required to meet the individual deductible to have benefits/cost share begin.

Your Medical Plan Options (cont'd)

CRH Americas Medical Options				
Plan Benefits	PPO Plan		HSA Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic X-Ray & Laboratory Services				
Office Visit	$25 PCP copay; $40 specialist copay	40% / 60%	20% / 80%	40% / 60%
Outpatient or Independent	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% Deductible waived	Not Covered	0% / 100% Deductible waived	Not covered
OB/GYN and Immunizations	0% / 100% Deductible waived	40% / 60%	0% / 100% Deductible waived	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 Max Per Calendar Year**	20% / 80%	40% / 60%	20% / 80%	40% / 60%
Hospice Care **In- or out-of-network benefits apply towards satisfying both maximums.**	20% / 80%	40% / 60%	20% / 80%	40% / 60%
Mental Health/ Chemical Dependency				
Inpatient Services **Hospital Services (Facility)** **Physician Services**	20% / 80%	40% / 60%	20% / 80%	40% / 60%
Outpatient Services **Office Visit (non-surgical)** **Emergency Treatment Room/Facility Charges** **Professional Provider**	$25 copay 100% after $150 copay 20% / 80%	40% / 60% 100% after $150 copay 40% / 60%	20% / 80%	40% / 60%

20%/80% means the employee is responsible for 20% and the plan covers the remaining 80% after the deductible is met.

Which Plan is Best for You? (Employee Only)

Below are **examples of hypothetical** employees and how the plan costs compare. 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 (Sample)						
Cost of Covered Services (Quantity of Services and Estimated Costs)	Low Utilizer		Medium Utilizer		High Utilizer	
	In-Network					
	PPO	HSA	PPO	HSA	PPO	HSA
[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)	$3,100 ($1,875 Applied to Ded + $1,225 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 copay x 12 months)	$840 ($70 copay x 12 months)	$600 (50% coin-surance x 12 months)
Cost of Covered Services (Payments you make directly to providers)	**$35**	**$192**	**$1,875**	**$2,392**	**$3,515**	**$5,130**
	+					
Annual Payroll Contribution (Enrolled in Employee Coverage, Standard Rate)	**$2,040** ($170/month)	**$1,128** ($94/month)	**$2,040** ($170/month)	**$1,128** ($94/month)	**$2,040** ($170/month)	**$1,128** ($94/month)
	=					
Cost of Covered Services	$35	$192	$1,875	$2,392	$3,515	$5,130
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**	**$5,758**

Which Plan is Best for You? (Employee + Spouse)

Below are **examples of hypothetical** employees and how the plan costs compare. 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 (Sample)						
Cost of Covered Services (Quantity of Services and Estimated Costs)	Low Utilizer		Medium Utilizer		High Utilizer	
	In-Network					
	PPO	HSA	PPO	HSA	PPO	HSA
[2] Preventive Care Visit: $160 Each	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)
[2] Primary Care Visit: $175 Each (Employee + 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)	$4,100 ($3,125 Ded + $975 Coinsurance)
[2] Generic Rx (10-day Supply): $17 (Employee + 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 copay 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**	**$7,372**
+						
Annual Payroll Contribution (Enrolled in Employee + Spouse Coverage, Standard Rate)	**$4,200** ($350/month)	**$2,200** ($185/month)	**$4,200** ($350/month)	**$2,200** ($185/month)	**$4,200** ($350/month)	**$2,200** ($185/month)
=						
Cost of Covered Services	$120	$834	$2,000	$3,284	$4,400	$7,372
Annual Payroll Contribution	$4,200	$2,200	$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**	**$8,842**

Which Plan is Best for You? (Family)

Below are **examples of hypothetical** employees and how the plan costs compare. 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 (Sample)						
Cost of Covered Services (Quantity of Services and Estimated Costs)	Low Utilizer		Medium Utilizer		High Utilizer	
	In-Network					
	PPO	HSA	PPO	HSA	PPO	HSA
[2] Preventive Care Visit: $160 Each	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)	$0 (Covered 100%)
[3] Primary Care Visit: $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)	$4,100 ($3,125 Ded + $975 Coinsurance)
[2] Generic Rx (10-day Supply): $17 (Employee + 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 copay x 12 months)	$840 ($70 copay x 12 months)	$600 (50% coin-surance x 12 months)
Cost of Covered Services (Payments you make directly to providers)	**$145**	**$1,009**	**$2,025**	**$3,459**	**$4,425**	**$6,947**
	+					
Annual Payroll Contribution (Enrolled in Employee + Family, Standard Rate)	**$5,880** ($490/month)	**$2,940** ($245/month)	**$5,880** ($490/month)	**$2,940** ($245/month)	**$5,880** ($490/month)	**$2,940** ($245/month)
	=					
Cost of Covered Services	$145	$1,009	$2,025	$3,459	$4,425	$6,947
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

What's Available at UMR.com?

You will find everything you want to know—and need to know—about your medical benefits at **www.umr.com** or call **800-207-3172**.

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

Finding a UMR Provider

Choose from quality doctors and hospitals that are part of your medical plan's network. Go to **www.umr.com**. Select the **UnitedHealthcare Choice Plus Network** to find available providers. Always call and confirm that a provider is in the UMR network to get the best rates. If you do use an out-of-network provider, consider negotiating the price before you receive service to avoid being balance billed.

NurseLine

UMR's NurseLine 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 the day, seven days a week.

Call NurseLine at **877-950.5083** or chat live online:

- Log in at **www.umr.com**
- Select Health Center from myMenu
- Look for the link in the *I need to…* section

Other resources can be found at **www.umr.com** or call **800-207-3172**.

If you need assistance with navigating mexdical claims or finding a provider, contact UMR at **800-207-3172.**

UMR CARE Programs

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 connect you with the services that best meet your needs.

Some examples of when UMR CARE can help you include:

- 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 for 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 **www.umr.com.**

UMR Mobile App

With just a tap, you can:

- Access your digital ID card
- View your plan details anytime
- Find out if there is a copay for your upcoming appointment
- Chat, call or message the UMR Member Support Team

Download on the App Store

GET IT ON Google Play

Virtual Healthcare | Teladoc Health

You will have 24/7 access to Teladoc U.S. board certified doctors through the convenience of your phone.

You and a practitioner can speak or video chat to answer questions, receive a diagnosis and even prescribe some medications for these and other common conditions:

- Colds
- Constipation
- Cuts that don't need stitches
- Ear or sinus pain
- Rashes
- Tolerable pain

Teladoc Visit Rates	
PPO Plan	**HSA Plan**
$10 copay/doctor, therapist or psychologist	deductible / coinsurance

Set Up Your Teladoc Account Before You're Sick

For fast access to virtual care, download the Teladoc app. Then select "Set up your account." Provide basic information about yourself for coverage verification. Choose your username and password and you're all set!

Download on the App Store

GET IT ON Google Play

Visit **TeladocHealth.com**, call **800-835-2362**, or download the app.

Regenexx

Replacing the need for up to 70% of elective orthopedic surgeries, Regenexx uses your body's natural healing agents to avoid surgery for your:

- Spine
- Hand/Wrist Elbow
- Knee
- Shoulder
- Hip
- Ankle/Foot

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.

Pre-certification is not required for these procedures. If you're enrolled in the PPO plan, you will pay the specialist copay for office visits. All other services are subject to the deductible and applicable coinsurance. If you're in the HSA plan, all services are subject to the deductible before coinsurance is applied.

To speak with a CRH Regenexx Patient Liaison call **866-385-4959** or visit **www.regenexxbenefits.com/crh** to learn more about Regenexx and alternatives to orthopedic surgery.

Find out if a Regenexx procedure is right for you. To sign up for a webinar, scan the QR code to register or visit **www.regenexxbenefits.com/webinar.**

Pharmacy | CVS Caremark

CVS Caremark provides our prescription drug plan, which is combined with the medical plan. CVS Caremark has a national network of pharmacies for your convenience, which includes CVS retail stores and most other large chains and independent pharmacies.

Drugs Covered by the Plan

Formularies list all of the prescription drugs, both generic and brand name, that are covered by the plan. They reflect the drugs that offer the greatest overall value. The lists are updated on a quarterly basis which may result in a brand name drug being excluded when a generic equivalent is covered. Generic drugs contain the same active ingredients as a brand name drug.

Your formulary is called the CVS Caremark Standard Control Formulary with Advanced Control Specialty Formulary and can be found online at **www.caremark.com.**

Caremark CVS Prescription Drug Benefits				
Benefit	**PPO**	**HSA**		
		Minimum	Member Coinsurance	Maximum
Rx Out-of-Pocket Maximum per calendar year	$3,450 Individual / $6,900 Family	See the medical deductible.		
Retail				
Generic	$10 copay	$5 after deductible	N/A	$5 after deductible
Preferred Brand	$35 copay	$15 after deductible	25% after deductible	$50 after deductible
Non-Preferred Brand	$70 copay	$30 after deductible	50% after deductible	$125 after deductible
Specialty	30% coinsurance	Subject to medical deductible/OOP maximum		
Mail Order /90-Day Retail				
Generic	$25 copay	$10 after deductible	N/A	$10 after deductible
Preferred Brand	$87.50 copay	$30 after deductible	25% after deductible	$100 after deductible
Non-Preferred Brand	$175 copay	$60 after deductible	50% after deductible	$250 after deductible

For more information about prescription drug coverage provided by this plan call **800-378-0458** or go to **www.caremark.com**.

Pharmacy (cont'd)

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 or coinsurance. 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.

Retail 90-Day Refills*

90-day refills provide savings for long-term maintenance medications that treat high blood pressure, high cholesterol, diabetes and more. 90-day supply refills are required after three 30-day fills of these medications. You may obtain a 90-day supply at a broad network of retail pharmacies and through home delivery. If you would like to opt out of mandatory Retail 90-Day Refills, call CVS Caremark.

Home Delivery Saves Time and Money*

Get up to a 3-month supply of the medications you take regularly when you enroll in the CVS Caremark Mail Service Pharmacy. Log into **www.caremark.com**, use the CVS Caremark app, or call CVS Caremark at **800-378-0458.**

**Please note that there are specific state laws/ regulations in place today that could affect how you receive medications as well as the cost depending on which state you reside in. These State laws can be approved/applied throughout the year, therefore this could potentially happen mid-year and not only on January 1.*

If you need assistance with specialty drugs, call **866-846-3095** or go to **www.cvsspecialty.com.**

CVS Specialty Pharmacy

Get your specialty medications and some clinical support for complex conditions, including cancer, arthritis and other conditions from the CVS Specialty Pharmacy.

PPO Plan Members PrudentRx Copay Program

- If you are in the CRH Americas PPO plan, you can get your covered specialty medications at no cost to you. That means $0 out-of-pocket for any medications on your Specialty Drug List when you fill them through CVS Specialty. The PrudentRx program works with manufacturers to get copay assistance and will manage enrollment and renewals in their programs on your behalf. Even if there is no copay help provided by a manufacturer for your medication, your cost will be $0 for as long as you are enrolled in the PPO plan and the PrudentRx program.

HSA Plan Members

- If you are in the CRH Americas HSA plan you pay the full cost of the medication until the deductible has been met. Applicable coupons may also be applied after the deductible.

Women's Health Initiative: Contraceptives

Generics and over-the-counter contraceptives are offered at no cost to women under the Pharmacy plan. Over-the-counter contraceptive products will not be covered.

Find a CVS Caremark pharmacy

Use the CVS Caremark app or visit **www.caremark.com.** The member ID # can be found on the front of your combined medical/pharmacy ID card.

Download on the App Store

GET IT ON Google Play

Understanding Prescription Drug Coverage

What is Prior Authorization for Drugs?

Prior Authorization (PA) means that your doctor or prescriber must show that the medication is necessary or that you have met the prior authorization requirements before your Plan will cover a particular 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
- Prior authorization 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, your doctor will need to start the process by contacting CVS Caremark.

What are Quantity Limits (QL)?

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 be taken twice a day equal to 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)?

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. This lowers your cost while still providing access to non-preferred medication.

What is a Dispense as Written (DAW) Penalty?

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.

Diabetic Supplies and Equipment

Diabetic drugs and supplies are covered under our medical or prescription drug plans. Some drugs listed may have additional requirements or limits, depending on the plan you're enrolled in.

The information in this section is provided for your reference and may not include all of the information you need. If you have further questions, please reach out to the UMR dedicated line at **800-207-3172** or CVS Member Services at **800-378-0458**.

Diabetic Equipment Facilities

Byram Healthcare Centers
www.byramhealthcare.com
877-902-9726

Minimed Distribution Corp
www.medtronicdiabetes.com/home
800-646-4633

North Coast Medical Supply d/b/a/ Advanced Diabetes Supplies
www.northcoastmed.com
866-422-4866

Insulet Corporation
www.myomnipod.com
800-591-3455

Tandem Diabetes Care
www.tandemdiabetes.com
858-375-1473

Important Note: The OmniPod 5 delivery system is supplied through pharmacies rather than durable medical equipment distribution vendors. If you use the OmniPod 5, it will be covered under the pharmacy plan with CVS. Other insulin pumps are considered durable medical equipment and are covered under the UMR medical plan.

Monitoring Devices and Meters Covered By Our UMR Medical Plan*

Continuous Blood Glucose Monitoring

Continuous Blood Glucose Monitoring (CGM) devices such as Dexcom and FreeStyle Libre are covered under the medical plan. Monitoring devices are covered by both plans:

PPO & HSA Plans**

- **20% coinsurance** after deductible (in-network)
- **40% coinsurance** after deductible (out-of-network)

Blood Glucose Meters

Blood glucose meters are covered under the medical plan. OneTouch glucometers are available **free of charge** under the CVS Caremark Free Meter Program by calling **800-588-4456**. Have your prescription ID number and your doctor's name and phone number handy when you call. Other monitoring devices are covered by both plans:

PPO & HSA**

- **20% coinsurance** after deductible (in-network)
- **40% coinsurance** after deductible (out-of-network)

See the list of Diabetic Equipment Facilities where you can purchase these devices at the in-network rate.

****Important Note: Pre-certification is required for durable medical equipment in excess of $1,000 purchase price. Contact UMR with any additional questions.***

Diabetic Supplies and Equipment (cont'd)

Diabetic Supplies and Medications Covered by Our CVS Pharmacy Plan		
Supplies and Medications	**CVS Preferred Brands**	**Excluded**
Diabetic Supplies (Test Strips, Needles, Syringes)	■ 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	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	Januvia, Januvia with pioglitazone, Janumet, Janumet XR, Saxagliptin, Saxagliptin-metformin ext-rel, Trijardy XR	Nesina, Onglyza, Tradjenta, Jentadueto, Jentadueto XR, Kazano, Kombiglyze XR, Oseni
Glucagon-Like Peptide-1 (GLP1) Agonist	Ozempic, Rybelsus, Trulicity, Victoza, Mounjaro	Bydureon Bcise, Byetta
Insulins (Short-Acting, Long- Acting, Basal)	Novolin 70/30*, Novolin N*, Novolin R*, Lantus, Toujeo, Tresiba *Re-branded or private label formulations are not covered without a prior authorization for medical necessity (i.e. Relion).	Humulin 70/30*, Humulin N*, Humulin R*, Basaglar, Levemir NOTE: Humulin R U-500 concentrate will not be subject to prior authorization and will continue to be covered.
Rapid-acting insulin	Fiasp, Novolog, Novolog Mix 70/30	Apidra, Humalog, Humalog Mix 75/25, Humalog Mix 50/50
Insulin Sensitizers and Combinations	Pioglitazone, Pioglitazone - Metformin, Pioglitazone - Glimepiride	Actos
Sodium-Glucose Cotransporter 2 (SGLT2) Inhibitors	Farxiga, Jardiance	Invokana
SGLT2 and Biguanide Combinations	Synjardy, Synjardy XR, Xigduo XR	Invokamet, Invokamet XR
SGLT2 and DPP4 Combinations	Glyxambi	Qtern
Disposable Insulin Pumps	Omnipod, V-Go	All other brands that are NOT Omnipod and V-Go

Dental Plan | Delta Dental

If you and/or your dependents are enrolled in the CRH Americas Health Plan, then you are automatically enrolled in the Delta Dental PPO plan. You can visit any dentist you like, but in-network dentists are contracted with Delta Dental to provide you with high quality care for lower cost.

If you use an out-of-network dentist, the plan will pay the same benefit level, but contracts aren't in place to limit the provider's rates. You're then responsible for any Reasonable and Customary (R&C) charges from the provider that is more than what Delta Dental has agreed to pay.

For questions about your dental coverage, contact Delta Dental at **www.deltadentalins.com** or call **800-521-2651.**

Delta Dental PPO Plan Benefits		
When you visit the dentist for your preventive exam and cleaning, the cost for these procedures will not be applied to your annual maximum benefit of $1,500.		
Deductible	Individual: $50, Family: $150	
Annual Maximum	$1,500 per person, in- or out-of-network combined	
Covered Service	**In-Network**	**Out-of-Network**
Diagnostic and Preventive (Cleanings, Fluoride, Sealants, routine X-rays)	0% / 100%	0% / 100% of R&C
Basic (Endodontics, Periodontics, Oral Surgery, general anesthesia)	20% / 80%	20% / 80% of R&C
Major (Crowns, Inlays, Onlays, Bridges, Implants)	50% / 50%	50% / 50%
Orthodontia (dependent under 19)	50% / 50%	50% / 50%
Orthodontia Lifetime Maximum (dependent under 19)	$1,500 lifetime maximum	$1,500 lifetime maximum
Implants	50% of negotiated rate (after the deductible); $1,500 annual maximum	

Treatment Frequency	
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

R&C stands for reasonable and customary

Vision Plan | EyeMed

If you and/or your dependents are enrolled in the CRH Americas Health Plan, then you and/or your dependents are automatically enrolled and covered by the EyeMed vision plan.

You may visit 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 then you'll need to file a claim to be reimbursed for any covered expenses.

For questions about your EyeMed vision coverage visit **www.eyemedvisioncare.com** or call **866-723-0513.**

EyeMed Vision Plan Benefits		
Service	**In-Network**	**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 **Bifocal** **Trifocal** **Standard progressive lens**	$20 copay	up to $30 up to $50 up to $65 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	
Standard anti-reflective coating	$45	
Polarized and other add-ons and services	20% off retail	
Contact Lens Fit and Follow-Up		
Conventional	$20 copay/$100 allowance, 15% off balance over $100	up to $90
Disposable	$20 copay/$100 allowance plus balance over $100	
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	
Frequency		
Exam / Eyeglass or contact lenses	Once every 12 months	
Frames	Once every 24 months	

Health Savings Account (HSA) | HealthEquity

When you are enrolled in the HSA Plan and contribute pre-tax payroll deductions to a Health Savings Account, you can use the funds to pay for qualified medical, dental and vision expenses for you and your eligible dependents. The funds in your HealthEquity HSA may be used today, saved in your account, or invested to help pay for future qualified expenses. To learn more about HSA accounts go to **https://learn.healthequity.com/crh**.

CRH Americas Puts Money in Your Account

After electing the HSA during enrollment for $0 or greater and setting up your account, CRH Americas will contribute funds to your account. To receive the employer portion, you must elect the HSA with an election of $0 or greater. Combined HSA contributions from you and CRH Americas cannot exceed the IRS limits that change annually.

Health Savings Account (HSA) Contributions for 2025			
If Your CRH Medical Coverage is for…	**CRH Contribution**	**Employee Eligible Election**	**Total IRS Allowable Maximum**
Employee Only	$500	$0 to $3,800	$4,300
Employee + Spouse	$750	$0 to $7,800	$8,550
Employee + Child(ren)	$750	$0 to $7,800	$8,550
Family	$1,000	$0 to $7,550	$8,550
Catch-up Contributions: If you are age 55 or older as of December 31, 2025, you can contribute an extra $1,000/yr.			

Are You Eligible to Open a Health Savings Account?

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

- You enroll in the CRH Americas HSA Plan for 2025
- Your only coverage is an HSA plan
- You are not covered by a traditional Health Care FSA through your spouse
- You are not covered by Medicare (part A or B), Tricare or VA Benefits*
- You are not claimed as a dependent on another person's tax return (unless it's your spouse)

If you're covered under your spouse's plan and that plan is not a qualified High Deductible Health Plan, you are not eligible to contribute to an HSA.

**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 Can You Use HSA Funds?

You can use the funds you accrue in your HSA 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)

Customer Identification Program (CIP)

When your HSA is opened, you will be required to comply with the Customer Identification Program (CIP) for identity verification to comply with the US Patriot Act of 2003. Financial institutions are required to obtain and verify specific customer data including name, date of birth, and Social Security number. You will need to verify any conflicting information in order to make or receive contributions to an HSA.

Health Savings Account (cont'd)

Can You Enroll in Both an HSA and Flexible Spending Account (FSA)?
If you are enrolled in an HSA you cannot open or contribute to the Health Care FSA. However, you can enroll in the HSA-Compatible Health Care Flexible Spending Account that can be used to pay eligible dental and vision expenses.

When are my HSA funds available to me?
Your total election amount is not available to you January 1. Your account balance builds throughout the year based on your payroll deductions and/or contributions from CRH. 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.

How do I access my HSA funds to pay for qualified expenses?
When you enroll in the HSA plan and open an HSA, you will receive a HealthEquity Accounts Card to use at your discretion for qualified expenses. You can choose to use the funds or build the balance in your HSA to save for unexpected expenses, or to 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 HealthEquity When you leave CRH, you can still access your HSA through **my.healthequity.com.**

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.You will have access to an integrated account and investment management on **my.healthequity.com**.

Are there administrative fees associated with an HSA?
The administration fees are covered by CRH Americas. 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 tax free.

Discover more ways to connect health and wealth.
Call **866-346-5800** or visit **HealthEquity.com.**

FSA/HSA Account Portal Login | HealthEquity

Logging into your member portal is easy. Simply follow steps below to access your HealthEquity account.

1 **Go to my.healthequity.com**

Under ***'Are you a member logging in for the first time?'*** click ***'Create username and password."***

2 **Verification code**

You will be prompted to do a verification step by entering the code on the screen.

3 **Find your account**

Enter the information requested on the ***"Find your account"*** screen.

4 **Verify your identity**

Enter the information asked for on the ***"Verify your identity"*** screen.

5 **Set up a login**

You will be prompted on the ***"Set up your login"*** Screen:

- Pick a user/login name of at least six characters with numbers and letter on the "set up your login" screen.
- Choose a password of at least eight characters with an uppercase letter, a lowercase letter and a number.

6 **Enter email**

On the ***"Your email settings"*** screen, enter your email address.

7 **Agree to terms of service**

Click the box to agree to the term of the website and save the agreement.

Health Care Flexible Spending Account (FSA)

Health Care FSAs allow you to save and use tax-free dollars to pay for eligible medical, dental or vision expenses not covered by insurance. All healthcare card purchases have to be verified within 90 days of the transaction date. HealthEquity Accounts will notify you if the transaction cannot be automatically verified and provide you with instructions for how to proceed. To learn more about FSA accounts, go to **https://learn.healthequity.com/crh.**

- Health Care FSA: Use this FSA if you **are** enrolled in the PPO medical plan.
- HSA-Compatible Limited Purpose FSA: Use this FSA if you **are** enrolled in the HSA medical plan.

	Health Care FSA	HSA-Compatible Limited Purpose FSA
Eligibility Requirements	**You can use this account for eligible expenses including health, dental and vision expenses not covered by insurance that you or your dependents incur.** ■ You must be enrolled in the PPO Plan	**You can use this account for eligible dental and vision expenses not covered by insurance that you or your dependent incurs.** ■ Available for anyone enrolled in a HSA Plan
What can 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:** $3,200	**Minimum Election:** $250 **Maximum Election:** $3,200
How do I enroll?	Enrollment can be completed at **www.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 $640 of any balance remaining at the end of the year into 2026. The $640 carryover will not affect the $3,200 limit for contributions in 2026. 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?	Claims must be incurred during the plan year of January through December and receipts submitted by March 31. The IRS requires HealthEquity to verify every purchase. Save all your receipts for purchases and the explanation-of-benefits documents that you get from UMR. The different kinds of documentation you can submit to verify a purchase include: ■ An explanation-of-benefits (EOB) document that you receive 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, bank statements or our own notes as documentation.	

Dependent Day Care Flexible Spending Account (DCFSA)

Money you contribute to the Dependent Day Care FSA can be used toward care for dependent children under the age of 13 who live with you and for whom you provide over 50% support, or for any dependent living with you who is physically or mentally incapable of self-care. To learn more about DCFSA accounts, go to **https://learn.healthequity.com/crh.**

The annual contribution limit for the Dependent Day Care FSA is $5,000 if you are single or married and filing a joint federal income tax return, or $2,500 if married and filing separate federal income tax returns. Expenses must be for a qualified childcare provider (someone who is claiming this income on his or her tax return) or for a certified day care facility.

Dependent Day Care Flexible Spending Account	
Eligibility Requirements	You can use this account to set aside pre-tax dollars to pay for day care expenses for eligible dependents—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 Election:** $5,000 If you are single **Maximum Election:** $5,000 If you are married and filing jointly **Maximum Election:** $2,500 If you are married and filing separate tax returns **Limit may be adjusted due to annual testing.*
How do I enroll?	Enrollment can be completed at **www.benefitsolver.com**. You will receive a debit card in the mail once enrollment is completed. Enrollment elections cannot be changed until the next annual open 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 deducted from 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 to apply for reimbursement of eligible expenses. Any funds remaining in your Dependent Day Care FSA after March 31 for eligible expenses incurred during the previous year will be forfeited.

Employee Assistance Program (EAP) | Optum

No-cost work/life resources for everyday support

We've partnered with Optum to bring you and your family **Live and Work Well**. This program is a confidential mental health, work/life and employee assistance resource center available 24/7 at **no cost to you**. With Emotional Wellbeing Specialists available by phone, you will be able to connect on a range of life concerns and stressors such as:

- 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

Talkspace

Reach out to a licensed network EAP provider 24/7—no appointment needed. Call Optum EAP to obtain an authorization code.

Digital Self-Care Tools

Visit **www.liveandworkwell.com** to access a digital suite of tools and resources to help you manage stress, anxiety and other concerns—all in one convenient location.

Financial Coaching from Experts

Receive up to 60 minutes of free consultation (provided in 30-minute increments) with a credentialed financial coach for each financial issue, as well as access to extensive legal/financial tools and libraries.

Scan this QR code to go directly to Live and Work Well from Optum.

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.

Connect with Your EAP and Work/Life Services

To start using your Optum EAP services call **866-248-4096** or visit **www.liveandworkwell.com** and enter company access code CRH. Web services are available in English and Spanish.

Calm App

Calm can help you tackle stress, get a good night's sleep and feel more present in your life. You also can use it to build coping skills and resiliency to navigate life's uncertainties. The Calm app is available **at no cost to you or your family** as a part of your benefits.

Download the Calm app for FREE:

1. Go to **Profile** at the bottom of the screen.
2. Click on the **"Settings"** icon in the upper left corner.
3. Select **"Link Organization Subscription."**
4. Enter Company Organization's Name **"Optum EWS."**
5. Enter Organization's Group code **"crh."**

Basic Life and AD&D Benefits for Employees
UNUM

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. Note: Death benefits exceeding $50,000 will be treated as imputed or ordinary income for tax purposes by the IRS.

Your 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 change of 15% or greater.

For more information about Basic Life and AD&D Insurance, go to **www-unum-com** or call **866.215.1720**.

Optional Life Insurance for Employees

You can add to your basic life insurance benefit by purchasing additional life insurance for yourself. Your contributions will be paid on an after-tax basis. You can buy optional life insurance in $10,000 increments up to 10 times your annual earnings not to exceed $2,000,000. Evidence of Insurability is required.

Increases in Coverage

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.

Basic Life and AD&D (cont'd)

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).
- **Annual 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 all year, however enrollment outside of your initial new hire enrollment period is considered a late entrant and is subject to EOI.

UNUM Life Insurance 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.

Optional Life Insurance for Employees

You can add to your basic life insurance benefit by purchasing additional life insurance for yourself. Your contributions will be paid on an after-tax basis. You can buy optional life insurance in $10,000 increments up to 10 times your annual earnings not to exceed $2,000,000. Evidence of Insurability is required.

Increases in Coverage

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.

Optional Life for Spouses

You can 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 Dependent Children

You have the opportunity to purchase life insurance for your dependent children (live birth to the last day of the year in which they turn 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.

Basic and Optional Life – Benefit Reduction for Age 70 and 75

When you turn 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 and Optional Life insurance for employees and Optional Life insurance 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.

Disability Plans | Unum

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 the first of the month following 60 days of continuous active employment. For more information about disability coverage, visit **www.unum.com** or call **866-215-1720**.

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.

UNUM Disability Benefits		
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 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 CRH Americas 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 expect 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, to 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.

CRH Americas 401(k) Retirement Plan | Fidelity

You will become eligible to participate in the 401(k) Plan on the first day of the month following the date you turn 18 years old 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 day 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 CRH Americas 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.

Administered by Fidelity Investments. For more information call **800-835-5095** or visit **www.401k.com**.

Fidelity 401(k) 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 NOT true-up the employer match to the 401(k) at the end of the year. 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 & Match Contribution	Immediately

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

CRH Americas 401(k) Retirement (cont'd)

Automatic Enrollment

If you are a CRH Americas 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 opt 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 the percentage you want to have deducted from your pay and placed in your 401(k) account. These salary deductions will generally begin with the next pay period after your information is received by Fidelity or as soon as administratively possible.

How do I designate my beneficiary?

As a new hire or if you experience 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.

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. (Note: At the point in time this document was finalized, the 2025 limits were not officially communicated by the IRS).

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 your 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. (Note: At this time the IRS has not released the 2025 401k limits).

What are the maximum IRS annual contribution limits?

For 2024, 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. Note: At this time the IRS has not released the 2025 401(k) limits. (Note: At this time the IRS has not released the 2025 401(k) contribution limits).

CRH Americas 401(k) Retirement (cont'd)

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 CRH Americas 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 CRH Americas 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 Benefits Team. 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). (Note: At this time, the IRS had not released the 2025 contribution limits).

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 are 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%

CRH Americas 401(k) Retirement (cont'd)

What are my investment options?

To help you meet your investment goals, the Plan offers you a range of options that best suit your goals, time horizon, and risk tolerance. They include conservative, moderately conservative, and aggressive funds. There are also investment options in company stock, 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 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 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**.
- Loan payments must be paid even when an employee is out on a leave of absence.

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**.

CRH Americas 401(k) Retirement (cont'd)

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. If you log on to NetBenefits and decline consent for online statements, you will receive your statements by mail. All other participants (those who have not logged onto NetBenefits) will default to online statement delivery. You 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**.

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. If you have questions, call **800-835-5095** to speak with a Fidelity Service Representative.

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**.

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?

CRH Americas 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 at **www.401k.com**.

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.

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

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.

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, 2024

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.

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, Atlanta. GA30338
888-437-4866
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.

1An 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.

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. geor-gia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra

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/ applica-tions-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.html
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 | 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

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.html | 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, 2024, 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)**.

Date: October 1, 2024

Name of Entity/Sender: CRH Americas, Inc.

Contact: CRH Americas Healthcare Plan

Address: 900 Ashwood Parkway, Atlanta, GA 30338

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.

Important Notices (cont'd)

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.

Important Notices (cont'd)

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 1**025 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

Notes

Benefits for Everywhere You Live, Work and Play

Employee Benefits Guide 2025

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

05529_CRHA_BG_MM

Gallagher