Envision®
BUILDING PRODUCTS LLC

Envision™
OUTDOOR LIVING PRODUCTS

FAIRWAY
ARCHITECTURAL RAILING SOLUTIONS

HELPING YOU UNDERSTAND
Your Benefit Choices

2024

CONTENTS

This is a high-level benefits guide of certain benefits **Envision Building Products, LLC** offers. The information in this booklet is intended as a general outline of the benefits offered under **Envision Building Products, LLC's** benefits program and should not be considered legal, investment or other benefits advice. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail. Benefit plans are subject to change, amendment, or termination without notice to or the agreement of any employee/participant. All protected health information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact the HR Administrator.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the "Notices" Section in the back of this benefits booklet.

**This guide may or may not be applicable to union employees.*

WELCOME

BENEFITS MENU | ENROLLMENT

BENEFITS OFFERED

MY HEALTH

Medical | **Highmark BCBS**
Dental | **Delta Dental of PA**
Vision | **EyeMed**
Health Savings Accounts | **BMO Harris Bank**
Flexible Spending Accounts | **Benecon**

MY LIFE

Life and AD&D | **Unum**
Disability | **Unum**

MY EXTRAS

Employee Assistance Program | **Unum**
Secure Travel Assistance | **Unum**
ID Theft Services | **Unum**
Will Center | **Unum**
Vision Discounts | **EyeMed**

IMPORTANT

You must notify the HR Administrator of any election changes within 30 days of the event.

Your Benefit Period

January 1, 2024 – December 31, 2024

ENROLLMENT

All team members have access to our online benefits enrollment platform 24/7 where you have the ability to enroll, select or change your benefits online during the annual open enrollment period, new hire orientation, and for qualifying events.

- ✓ **Accessible 24/7;**
- ✓ **View all benefit plan options and your elections;**
- ✓ **View important carrier forms and links;**
- ✓ **Report a qualifying life event; and**
- ✓ **Make changes to beneficiary designations and more.**

ENROLLMENT INSTRUCTIONS:

1. Go to www.employeenavigator.com and click Login
   - Returning Users: You will need to create a new, different username and password
   - First-Time Users: Click on your registration link in the email sent to you by your administrator or register as a new user
   - **Employer Identifier: envisionbp**
2. Click Start Enrollment and follow instructions to enroll in your benefits
3. Make sure to save your elections and print your confirmation statement.

READY TO ENROLL?

Go to www.employeenavigator.com

Helpful Tips To Consider Before You Enroll

1. **Do you plan to enroll an *eligible dependent(s)*?**
   If so, make sure to have their social security numbers and birthdates available. You cannot enroll your dependent(s) without this information.
2. **Have you recently been *married/divorced or had a baby*?**
   If so, remember to add or remove any dependent(s) and/or update your beneficiary designation.
3. **Did any of your covered children reach their *26th birthday this year*?**
   If so, they may no longer be eligible for benefits.

ELIGIBILITY
RULES | REQUIREMENTS

EMPLOYEE ELIGIBILITY

You are eligible to participate if you are full-time and work a minimum of 30 hours per week Your coverage will be effective the 61st day of employment.

DEPENDENT ELIGIBILITY

You may also enroll eligible dependents for benefits coverage. A **'dependent'** is defined as the **legal spouse** and/or '**dependent child(ren)'** of the plan participant or the spouse.

The term 'child' refers to any of the following:

- A natural (biological) child;
- A stepchild;
- A legally adopted child;
- A foster child;
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse/domestic partner; or
- Disabled dependents may be eligible if requirements set by the plan are met.

The chart provided below explains who is eligible for coverage under each benefit plan type:

Line of Coverage	When coverage ends
Medical, Dental, Vision	The **last day you are eligible**
Spouse Life Insurance	No termination date due to age
Child Life Insurance	The **day** the child turns **age 26**.

Qualifying Life Events

If you have a Qualifying Life Event and want to request a mid-year change, you must notify the HR Administrator and complete your election changes within 30 days following the event. Be prepared to provide documentation to support the Qualifying Life Event.

Common life events include; Marriage, Divorce, New Dependent, Loss/gain of available coverage by you or any of your dependents.

A full list of qualifying events can be found in the 'Required Notices' section of this benefits guide.

IMPORTANT

You cannot make changes to these elections during the year unless you experience a qualified family status change, which must be reported to the HR Administrator within 30 days of the event.

If you separate from employment, COBRA continuation of coverage may be available as applicable by law. COBRA Continuation details can be found in the notices section of this employee benefit guide.

HEALTH
MEDICAL | PRESCRIPTION DRUGS

COMMON INSURANCE TERMS

A **PREMIUM** is the amount you pay for insurance, using pre-tax or post-tax dollars.

A **COPAYMENT (COPAY)** is a fixed amount you pay to receive services. Your co-payment(s) will count towards your out-of-pocket maximum but not your deductible. (e.g., $40 for every visit to the doctor), while your insurance company pays the rest.

A **DEDUCTIBLE** is the amount of money you are responsible for paying each year before the plan begins to pay for covered services, with the exception of preventive care services, which are covered at 100% In-Network.

COINSURANCE This is your share of the expense of covered services after your deductible has been paid when the company plan is paying a percentage. The coinsurance rate is usually a percentage.

OUT-OF-POCKET (OOP) MAXIMUM is the most you pay per Plan Year for health care expenses and applies to deductibles, flat-dollar copays and coinsurance for all covered services – including cost-sharing amounts for prescription drugs.

Once this limit is met, the plan will cover all in-network services at 100% until the end of the plan year.

***OUT-OF-NETWORK** charges in the above plans are subject to reasonable and customary limitations, which means you are responsible for charges over this amount in addition to separate deductible and coinsurance. Any services received from an out-of-network provider, with the exception of a true emergency, will not be covered.

PPO | In-Network & Out-of-Network Benefits Available

The PPO option offers the freedom to see any provider when you need care. When you use providers from within the PPO network, you receive benefits at the discounted network cost. Most expenses, such as office visits, emergency room and prescription drugs are covered by a copay. Other expenses are subject to a deductible and coinsurance.

PPO HSA | In-Network & Out-of-Network Benefits Available

The HDHP is similar to the PPO Plan in that you have the option to choose any provider when you need care. However, in exchange for a lower per-paycheck cost, you must satisfy a higher deductible that applies to almost all health care expenses, including those for prescription drugs.

All expenses are your responsibility until the deductible is reached, with the exception of preventive care, which is covered at 100% when you visit a physician in the network.

Enrolling in this plan allows you to contribute tax free dollars to a health savings account (HSA). Any dollars that you wish to contribute can be used towards any eligible medical, Rx, dental and vision expenses that you may incur while covered under the plan. See HSA section of this guide for additional details.

HIGHMARK

Did You Know?

- ✓ **Preventive Services** are c**overed at 100% In-Network** and copays & deductibles do not apply.
- ✓ You **pay less** out of pocket if you receive care from an **In-Network provider.**

How do I find an In-Network Provider?

In-Network providers can be found on your provider's website (www.highmarkblueshield.com) under "Find a Doctor or Hospital". Select "Search as Guest" and search for in-network providers through your employer, choosing the network based on the plan type you are choosing.

MEDICAL & PRESCRIPTION

HEALTH | PLAN COMPARISON

HIGHMARK.

IN-NETWORK BENEFITS	HDHP Plan Network	HDHP Plan Non-Network	PPO Plan Network	PPO Plan Non-Network
DEDUCTIBLE				
Single Deductible	$3,200	$6,400	$2,900	$5,800
Family Deductible	$6,400	$12,800	$5,800	$11,600
COINSURANCE *(applies after deductible is met)*				
Member Cost Share %	0%	20%	0%	20%
Health Savings Account				
Eligible Plan for HSA	Yes		No	
MEMBER COPAYMENT(S)				
Primary Care (PCP) - Office Visit	0% after ded.	20% after ded.	$20 copay	20% after ded.
Specialist - Office Visit	0% after ded.	20% after ded.	$40 copay	20% after ded.
Urgent Care Facility	0% after ded.	20% after ded.	$50 copay	20% after ded.
Emergency Room Visit	0% after deductible		$150 copay	
PRESCRIPTION COPAYMENT(S) (RETAIL / MAIL ORDER)				
Generic	0% after ded.		$15 copay	
Preferred Brand	0% after ded.		$30 copay	
Non-Preferred Brand	0% after ded.		$50 copay	
OUT-OF-POCKET (OOP) MAXIMUM				
Single Maximum	$3,200	Unlimited	$7,900	Unlimited
Family Maximum	$6,400	Unlimited	$15,800	Unlimited

BI-WEEKLY EMPLOYEE CONTRIBUTIONS	HDHP No Discount	HDHP With Wellness Discount*	PPO No Discount	PPO With Wellness Discount*
Employee Only	$96.13	$86.52	$99.82	$89.84
Employee + Spouse**	$254.92	$229.43	$266.03	$239.43
Employee + Child(ren)	$237.93	$214.14	$248.28	$223.45
Family	$328.57	$295.71	$351.59	$316.43

*Note: * Must have completed the Wellness program to qualify for discount.*
*** $100 additional per pay deduction for spousal coverage will apply if spouse is eligible for other coverage.*

Your Care Options and When to Use Them.

Primary Care Physician (PCP)

For routine, primary/preventive care, or non-urgent treatment, we recommend going to your doctor's office for medical care. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out-of-pocket when you receive care in your doctor's office.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms look a lot like the urgent care centers you are likely used to, but the costs and services are drastically different. In general, consider an urgent care center as an extension of your PCP, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are covered by your insurance plan's network; note that balance billing may apply. Choosing an urgent care center instead of an emergency room for everyday health concerns could save you hundreds of dollars.

ConnectCare3

ConnectCare3

ConnectCare3 is a confidential benefit provided to employees and their dependents covered under the health plan at no additional cost. ConnectCare3 has no affiliation with any insurance carrier or hospital system. Their aim is to provide callers with positive health outcomes on your health and wellness journey.

Available Services:

Patient Advocacy

The patient advocates are the first line of contact when reaching out to ConnectCare3. They also assist our clinical team with conducting research.

Nurse Navigation

The nurse navigators are available to work with patients who have received a medical diagnosis that requires a specialist. Our nurses can provide education on a diagnosis and treatments, physician options, and can help patients prepare for physician appointments.

Chronic Disease Management & Prevention

The Chronic Disease Management & Prevention team consists of registered nurses, certified health coaches, and a registered dietitian. Our team approach to preventing and managing chronic conditions provides you with access to resources and expertise all in one place.

Nutrition Education

Our registered dietitian will help patients to understand the connection between diet and health by completing a thorough nutritional assessment and providing health meal plans and alternatives.

Tobacco Cessation

Work one-on-one with our Tobacco Cessation coaches to achieve and maintain a tobacco-free life.

ConnectCare3®

Visit **www.connectcare3.com**

Call **877-223-2350** or email **info@connectcare3.com** to enroll in services.

HEALTH SAVINGS ACCOUNT

HSA | TAX SAVING VEHICLE

ENROLLED IN AN HSA ELIGIBLE HEALTH PLAN?

Take charge of your health care spending with a Health Savings Account (HSA). Contributions to an HSA are tax-free, and no matter what, the money in the account is yours!

A Health Savings Account (HSA) is a tax-free savings account owned by you, is 100% vested from day one, and let's you build up savings for future needs. The funds may be used to pay for qualifying healthcare expenses* not covered by insurance or any other plan for yourself, your spouse, or tax dependents. You decide how much you would like to contribute, when and how to spend the money on eligible expenses, and how to invest the balance.

**A full list of qualified expenses can be found in IRS Publication 502 at www.irs.gov*

UNDERSTANDING YOUR HSA

- Pre-tax contributions are deducted through payroll and deposited into your HSA account;
- You can use your HSA available funds to pay for qualified medical expenses tax-free;
- HSA funds can be used for non-eligible expenses but will be subject to regular income taxes and a 20% excise tax penalty.
- Unused funds remain in your account for future use and roll over each calendar year;
- HSAs remain with you even if you change health plans or companies. If you open an HSA and later become ineligible to make contributions, you can still use your remaining funds; and
- You can change your HSA contribution at any time during the plan year for any reason.

MAINTAINING RECORDS

To protect yourself in the event that you are audited by the IRS, keep records of all HSA documentation and itemized receipts for at least as long as your income tax return is considered open (subject to an audit), or as long as you maintain the account, whichever is longer.

HSA funds may be used for non-eligible expenses but will be subject to regular income taxes and a 20% excise tax penalty.

HSA ELIGIBILITY REQUIREMENTS

- ✓ To be eligible to open and contribute to an HSA, you must have coverage under a qualified High Deductible Health Plan (HDHP).
- ✓ Participants cannot be covered by any other health insurance plan (this exclusion does not apply to certain other types of insurance, such as dental, vision, disability or long-term care coverage);
- ✓ Participants cannot participate in a Healthcare FSA or spouse/domestic partner's Healthcare FSA or Health Reimbursement Account (HRA).
- ✓ Participants cannot be enrolled in Medicare or Medicaid *(including dependents)*.
- ✓ You cannot be eligible to be claimed as a dependent on someone else's tax return.
- ✓ You have not received Department of Veterans Affairs Medical benefits in the past 90 days.

2024 | HSA FUNDING LIMITS

Each year, the IRS places a limit on the maximum amount that can be contributed to HSA accounts.

HSA Contribution Limits	
Employee	$4,150
Family	$8,300

HSA "Catch-Up" Contributions	
Age 55 or older	$1,000 a year

Employer HSA Contribution	
All Employees Electing HDHP Plan	$500 ($19.23 Per Pay Period)

Employee Contribution Maximum (after employer contribution)	
Employee	$3,650
Family	$7,800

Source: IRS, Rev. Proc. 2021-30

FLEXIBLE SPENDING ACCOUNT

FSA | TAX SAVING VEHICLE

Flexible Spending Accounts (FSA) allow you to reduce your taxable income by setting aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket health care and dependent care expenses* for yourself, your spouse and your dependent children.

In order to participate in the FSA, you must enroll each year. Your annual contribution stay in effect during the entire year **(January 1st through December 31st)**. The only time you can change your election is during the enrollment period or if you experience a change-in-status event. Also, you must elect this benefit within **30 days** of your hire date or first date of benefits eligibility.

ELIGIBLE EXPENSES

- A full list of qualified FSA expenses can be found in IRS Publication 502 at **www.irs.gov**.
- You can learn more about FSA qualified expenses and also make purchases by visiting the FSA Store at **www.fsastore.com**.

HEALTH CARE & LIMITED PURPOSE FSA

MAXIMUM ANNUAL CONTRIBUTION | $3,200

Minimum Contribution | $260

All eligible health care expenses – such as deductibles, medical and prescription copays, dental expenses, and vision expenses – can be reimbursed from your general purpose FSA account.

With the Health Care FSA or Limited Purpose FSA, you can spend up to the full amount of your annual election as soon as your account has been set up.

LIMITED PURPOSE FSA | ADDITIONAL REQUIREMENTS

MAXIMUM ANNUAL CONTRIBUTION | $3,200

Minimum Contribution | $260

- If you open or contribute to a Health Saving Account (HSA), you may only enroll in a Limited Purpose FSA.
- If you enroll in a HDHP (High Deductible Health Plan) and elect a Health FSA, you will automatically be enrolled in the Limited Purpose FSA.
- A limited purpose FSA will reimburse you for dental and vision expenses, but you cannot claim the same expense on both the FSA and HSA Accounts.

DEPENDENT CARE FSA

The Dependent Care FSA allows you to pay for eligible dependent care expenses with tax-free dollars so that you and your spouse can work or attend school FT.

Unlike the Health Care FSA, funds in a Dependent Care FSA are only available once they have been deposited into your account and you cannot use the funds ahead of time.

- You may set aside up to **$5,000** annually in pre-tax dollars, or **$2,500** if you are married and file taxes separately from your spouse.
- If you participate in a Dependent Care FSA, you cannot apply the same expenses for a dependent care tax credit when you file your income taxes.

IMPORTANT FSA RULES

HEALTH CARE FSA ROLLOVER

Health Care FSA's have a **$640 roll over** feature, which allows any amount of $640 or less remaining in your account at the end of the plan year to roll over into the new plan year.

At the end of each plan year, you may use these funds left over from the current year FSA balance.

DEPENDENT CARE FSA "USE IT" OR "LOSE IT"

"Unused" FSA funds do not roll over from year to year. ***If you don't use the funds in your account by December 31, 2024, you'll lose them.***

The **Dependent Care FSA** has a grace period. This means you have until March 15, 2025, to submit your claims, incurred in 2024, for reimbursement.

**ELIGIBLE DEPENDENT CARE EXPENSES INCLUDE:*

1. **'Care'** for your dependent child who is under the age of 13 that you can claim as a dependent on your federal tax return;
2. **'Care'** for your dependent child who resides with you and who is physically or mentally incapable of caring for themselves; or
3. **'Care'** for your spouse, parent or grandparent who is physically or mentally incapable of caring for themselves and spends at least eight hours a day in your home.

'Care' is defined as: In-home baby-sitting services (not by an individual you claim as a dependent); care of a preschool child by a licensed nursery or day care provider; before and after-school care; summer day camp (provided it is not overnight); and in-home dependent day care.

DENTAL
COVERAGE OVERVIEW

COMMON TERMS

PRE-TREATMENT ESTIMATE
If your dental care is extensive and you want to plan ahead for the cost, you can ask your dentist to submit a pre-treatment estimate. While it is not a guarantee of payment, a pre-treatment estimate can help you predict your out-of-pocket costs.

DUAL COVERAGE
You might have benefits from more than one dental plan, which is called dual coverage. In this situation, the total amount paid by both plans can't exceed 100% of your dental expenses. And in some cases, depending on the specifics of the plans, your coverage may not total 100%.

LIMITATIONS AND EXCLUSIONS
Dental plans are intended to cover part of your dental expenses, so coverage may not extend to your every dental need. A typical plan has limitations such as the number of times you can receive a cleaning each year. In addition, some procedures may be not be covered under your plan, which is referred to as an exclusion.

DELTA DENTAL®

PREVENTION FIRST!

Your dental health is an important part of your overall health. Make sure you take advantage of your preventive dental visits.

Preventive care services are covered at 100% if you visit an In-Network provider. They are also not subject to the annual deductible.

You have the freedom to select the dentist of your choice; however when you visit a participating in-network dentist, you will have lower out-of-pocket costs, no balance billing, and claims will be submitted by your dentist on your behalf.

PLAN FEATURES	High Plan PPO / Premier / Non-Network*	Low Plan PPO / Premier / Non-Network*
DEDUCTIBLE		
Single	$50	$0
Family	$150	$0
When does it apply?	When receiving Basic or Major services (Does not apply for Preventive or Orthodontia services)	
COVERED SERVICES		
CLASS I: Preventive Services *Routine exams & cleanings, x-rays, sealants, fluoride treatments & space maintainers*	Covered at 100% / 100% / 100%	Covered at 100% / 100% / 100%
CLASS II: Basic Services *Endodontics, palliative care, stainless steel crowns, fillings, oral surgery & general anesthesia*	Covered at 80% / 80% / 80%	Covered at 80% / 80% / 80%
CLASS III: Major Services *Periodontics, prosthodontic repairs, crowns, inlays/onlays, dentures, & bridges*	Covered at 50% / 50% / 50%	Not Covered
CLASS IV: Orthodontic Services For covered members to Age 26	Covered at 50% / 50% / 50%	Not Covered
ANNUAL MAXIMUM		
Maximum Benefit *Allowed per Benefit Period*	$1,500 per covered individual	$1,000 per covered individual
Orthodontia Maximum Benefit *Allowed per Lifetime*	$1,500 per covered individual	N/A

**Non-Network services can potentially be balance-billed.*

SMILEWAY
SmileWay is included with your Delta Dental benefits and offers employees who have been diagnosed with certain chronic conditions to receive additional cleanings every year. Chronic conditions include diabetes, heart disease, HIV/AIDS, rheumatoid arthritis, or stroke.

Bi-Weekly Employee Contributions

Tier	High Plan	With Wellness Discount	Low Plan	With Wellness Discount
Employee Only	$8.62	$7.76	$6.13	$5.52
Employee & Spouse	$17.46	$15.71	$12.41	$11.17
Employee & Child(ren)	$22.19	$19.97	$15.22	$13.70
Employee & Family	$31.03	$27.93	$21.50	$19.35

How do I find an In-Network Provider?
This dental plan offers deeper discounts when you visit a provider that is In-Network. In-Network providers can be found on **www.deltadentalins.com.** Enter your zip code and choose the Delta Dental PPO network. It is encouraged to call the dentist directly to verify whether they are contracted with the PPO or Premier network.

DENTAL

EDUCATIONAL PIECE

Carrier – Delta Dental of PA

- Available to all eligible employees and dependents who would like to elect coverage
- Delta Dental tiered network of dentists – **Delta Dental PPO or Delta Dental Premier**
  - You can go to any licensed general or specialty dentist.
  - You will maximize your benefits by receiving care from a Delta Dental PPO or Delta Dental Premier network dentist.
  - Delta Dental's network dentists have agreed to reduced fees as payment in full, which means you will likely save money by going to a Delta Dental PPO or Delta Dental Premier network dentist. Non-network dentists have not agreed to accept the reduced fees as payment in full, which means they may bill you for any charges over the allow fees.
  - With **Delta Dental PPO,** you will pay the least out of pocket. PPO Dentists cannot "balance bill", meaning they cannot bill you for the difference between what they usually charge and the established PPO fee.
  - With **Delta Dental Premier,** you will pay more out of pocket compared to a PPO dentist. Premier Dentists accepted fees are higher than PPO, meaning both you and Delta Dental will pay more for a service and you could be balanced billed.
  - You are charged only the patient's share at the time of treatment. Delta Dental pays its portion directly to network dentists.

Network Cost Share Example:

Example Savings for a Common Procedure

	Estimated Charge	Maximum Allowed Fees	Percentage Paid by Delta Dental	Amount Delta Dental Pays	Amount Dentist can Balance Bill	Total Amount You Pay	Your Total Cost Savings
PPO Network	$1,200	$750	50%	$375	$0	$375	$450
Premier Network	$1,200	$975	50%	$487.50	$0	$487.50	$225
Out-of-Network	$1,200	$975*	50%	$487.50	$225	$712.50**	$0

Delta Dental PPO network

Delta Dental PPO network dentists have agreed to accept $750 as payment in full for the $1,200 service, a savings of $450 compared to using a non-network dentist. In this example, the Delta Dental plan covers 50 percent of the cost. Assuming you've already met your deductible for the year, Delta Dental will pay $375 and you'll pay $375.

Delta Dental Premier® network

Delta Dental Premier network dentists have agreed to accept $975 as payment in full – a savings of $225 compared to using a non-network dentist. In this example, your Delta Dental plan covers 50 percent of the cost. Assuming you've already met your deductible for the year, Delta Dental will pay $487.50 and you'll pay $487.50. That's an extra $112.50 tacked on to your share of the bill when compared to what you would have paid with a PPO dentist.

Out-of-network

Out-of-network dentists have not agreed to accept a lower fee as payment in full and can bill the full $1,200. In this example, non-network dentists are paid off the Delta Dental Premier maximum plan allowance, so the maximum allowed fee is limited to $975*. The dentist can bill you the difference between the maximum allowed fee and what they typically charge.** The Delta Dental plan would cover 50 percent of the $975, paying $487.50. You would be left with the other half of $487.50 plus the $225 difference between the dentist's usual fee and Delta Dental's maximum allowed fees. You would pay a total of $712.50.

VISION
COVERAGE OVERVIEW

Under this plan, you may use the eye care professional of your choice. However, when you visit a participating in-network provider, you receive higher levels of coverage. If you choose to receive services from an out-of-network provider, you will be required to pay that provider at the time of service and submit a claim form for reimbursement.

PLAN FEATURES	INSIGHT Network	Non-Network
Vision Exam	**$10** copay	Up to **$40**
COVERED SERVICES – LENSES / FRAMES		
Single Lenses	**$10** copay	Up to **$30**
Bifocals	**$10** copay	Up to **$50**
Trifocals	**$10** copay	Up to **$70**
Frames	**$130** retail allowance, 20% off balance over $130	Up to **$91**
COVERED SERVICES		
Contact Lenses	**$130** retail allowance, 15% off balance over $150	Up to **$91**
Contact Lens Evaluation Fitting	**Up to $40 copay**	Not Covered
BENEFIT FREQUENCY		
Exams	Once every 12 Months	Once every 12 Months
Lenses	Once every 12 Months	Once every 12 Months
Frames	Once every 12 Months	Once every 12 Months
Contacts	Once every 12 Months *(contacts in lieu of frames/lenses)*	Once every 12 Months

Bi-Weekly Employee Contributions	
Tier	
Employee Only	$2.65
Employee & Spouse	$5.30
Employee & Child(ren)	$5.04
Employee & Family	$7.95

Did you know your eyes can tell an eye care provider a lot about you?

In addition to eye disease, a routine eye exam can help detect signs of serious health conditions like diabetes and high cholesterol. This is important, since you won't always notice the symptoms yourself and since some of these diseases cause early and irreversible damage.

Need to locate a participating In-Network provider?

Visit
www.eyemedvisioncare.com/locator/

Search by location and/or provider name and choose the Insight network.

BASIC LIFE
COVERAGE OVERVIEW

BENEFICIARY(IES)

It's very important to designate beneficiaries. Taking a few minutes to designate your beneficiaries now will help ensure that your assets will be distributed according to your direction.

A Beneficiary is the person you designate to receive your life insurance benefits in the event of your death. It is important that your beneficiary designation is clear so there is no question as to your intentions.

It is also important that you name a **Primary** and **Contingent Beneficiary.** A contingent beneficiary will receive the benefits of your life insurance if the primary beneficiary cannot. You can change beneficiaries at any time.

You should review your beneficiary elections on a regular basis to ensure they are updated as life changes. Even if you are single, your beneficiary can use your Life Insurance to pay off your debts, such as: credit cards, mortgages, and other expenses.

**You designate your beneficiary(ies) when enrolling for your benefits.*

BASIC LIFE INSURANCE

Life insurance is an important part of your financial security. Life insurance helps protect your family from financial risk and sudden loss of income in the event of your death. AD&D insurance is equal to your Life benefit in the event of your death being a result of an accident, and may also pay benefits for certain injuries sustained.

Company Paid Benefit - Provided to you at no cost	
Coverage Amount	1x Salary to $250,000
Accidental Death and Dismemberment (AD&D)	Amount equal to your Life benefit
Benefit Reduction Schedule	Your insurance will reduce to: – 65% of the original amount at age 70 – 50% of the original amount at age 75

ADDITIONAL PLAN PROVISIONS

Portability	If your employment ends or your retire, you may be eligible to continue your term insurance at group rates.
Conversion	When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.

WHAT WILL MY BENEFICIARY RECEIVE?

In The Event That Death Occurs:

- Your Basic Life insurance is paid to your beneficiary.
- **If death occurs from an accident:** 100% of the AD&D benefit would be payable to your beneficiary(ies) in addition to your Basic Life insurance.

SUPPLEMENTAL LIFE
COVERAGE OPTIONS FOR YOU & THE FAMILY

SUPPLEMENTAL LIFE INSURANCE

Employees have the opportunity to enroll in supplemental Life insurance. If you choose to enroll in employee coverage, this will be in addition to **Envision Building Products, LLC** provided Basic Life coverage. Coverage is also available for your spouse and/or child dependents. It is typically required that you elect coverage for yourself in order to be eligible for coverage on your dependents.

PLAN OPTIONS			
Cost of Coverage	Premiums are based on age-rated tables and paid by the employee every pay period through a payroll deduction. These premiums are post-tax and benefits payable are tax-free.		
Coverage Options	**Employee Coverage** Choose in $10,000 increments up to the lesser of 5x your annual salary or $500,000	**Spouse Coverage** Choose in $5,000 increments up to the lesser of 100% of the amount you elect for yourself or $250,000	**Dependent Coverage** Live Birth – 6 Months: $1,000 6 Months – 26 Years: $5,000 or $10,000
Do I have to take a health exam to get coverage?	If you and your dependents enroll in coverage at your initial eligibility date, you may apply for up to the Guaranteed Issue amounts without medical questions.		
Guaranteed Issue	**Employee** $110,000	**Spouse** $25,000	**Dependent** $10,000

PLAN PROVISIONS		
Cost Calculation	Age Rated Benefit (Spouse Life based on spouse's age)	
Benefit Reduction Schedule	**Employee Coverage Will Reduce To:** – 65% of the original amount at age 70 – 50% of the original amount at age 75	**Spouse Coverage Will Reduce By:** The same amount and at the same time your coverage reduces
Portability	If your employment ends or you retire, you may be eligible to continue your term insurance at group rates.	
Conversion	When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.	

*Guaranteed Issue (GI) and Evidence of Insurability (EOI)

When you are first eligible (at hire) for Voluntary Life and AD&D, you may purchase up to the Guaranteed Issue (GI) for yourself and your spouse without providing proof of good health (EOI). Annually, you are able to increase elections by $10,000 up to GI without proof of good heath.

Any amount elected over the GI will require EOI. If you elect optional life coverage, and are required to complete an EOI, it is your responsibility to complete the EOI and send to the provider (address will be listed on your form). In addition, your spouse will need to provide EOI to be eligible for coverage amounts over GI, or if coverage is requested at a later date.

Be advised, the EOI file is open for 60 days.

UNUM®

Bi-Weekly Supplemental Life & AD&D Rates

Age	Employee Rate per $1,000 of Benefit	Spouse Age Rate per $1,000 of Benefit
<25	$0.038	$0.026
25 - 29	$0.038	$0.030
30 – 34	$0.049	$0.044
35 – 39	$0.070	$0.065
40 – 44	$0.108	$0.097
45 – 49	$0.170	$0.150
50 – 54	$0.252	$0.223
55 - 59	$0.366	$0.324
60 – 64	$0.481	$0.442
65 – 69	$0.678	$0.636
70 – 74	$1.284	$1.201
75+	$3.967	$3.714
Child Life	$0.152	
Employee, Spouse & Child AD&D	$0.018 / $0.014 / $0.028	

DISABILITY

SHORT-TERM | LONG-TERM

SHORT-TERM DISABILITY (STD)

Everyday illnesses or injuries can interfere with your ability to work. Even a few weeks away from work can make it difficult to manage household costs.

Short Term Disability coverage provides financial protection for you by paying a portion of your income, so you can focus on getting better and worry less about keeping up with your bills.

LONG-TERM DISABILITY (LTD)

Serious illnesses or accidents can come out of nowhere. They can interrupt your life, and your ability to work for months – even years.

Long Term Disability provides financial protection for you by paying a portion of your income, so you have financial support to manage your disability and your household.

PLAN FEATURES	SHORT-TERM DISABILITY (STD)	LONG-TERM DISABILITY (LTD)
Cost of Coverage	**This benefit is paid for by Envision Building Products, LLC**	**This benefit is paid for by Envision Building Products, LLC**
Elimination Period *This is the number of days that must pass between your first day of a covered disability & the day you can begin to receive your disability benefits.*	Benefits begin on the **8th day of an accident** and the 8th **day of an illness (including pregnancy)**	Your elimination period is **180 days**
Benefit Duration *The maximum number of weeks you can receive benefits while you are sick or disabled.*	**Payments may last up to 26 weeks** **Maternity: 6 weeks, 8 weeks if C-Section** You must be sick or disabled for the duration of the waiting period before you can receive a benefit payment.	**Payments will last for as long as you are disabled, or until you reach Retirement Age (age 65), whichever is sooner** You must be sick or disabled for the duration of the elimination period before you can receive a benefit payment.
Coverage Amount	Covers **60% of your weekly income,** up to a maximum benefit of **$1,055 per week.**	Covers **60% of your monthly income,** up to a maximum benefit of **$6,000 per month.**
What's covered?	**A variety of conditions and injuries.** Typical claims would include: pregnancy, injuries, joint, back and digestive disorders.	**A variety of conditions and injuries.** Typical claims would include: cancer, back disorders, injuries and poison, cardiovascular, joint disorders.
Definition of Earnings	**Base Salary** *(excludes commissions and bonuses)*	**Base Salary** *(excludes commissions and bonuses)*
Pre-Existing Condition Limitation	No Limitation	You have a pre-existing condition if you have received: medical treatment, consultation, care or services including diagnostic measures for the condition, or took prescribed drugs or medicines for it in the 3 months just prior to your effective date of coverage; and the disability begins in the first 12 months after your effective date of coverage.

Certain exclusions and any pre-existing condition limitations may apply. Please refer to the Provider's detailed benefit summary for details.

NEW JERSEY EMPLOYEES ONLY – STATE MANDATED COVERAGE

PLAN FEATURES	NEW JERSEY SHORT-TERM DISABILITY (STD)
Cost of Coverage	**This benefit is paid for by Envision Building Products, LLC**
Elimination Period *This is the number of days that must pass between your first day of a covered disability & the day you can begin to receive your disability benefits.*	Benefits begin on the **8th day of an accident** and the **8th day of an illness (including pregnancy)**
Benefit Duration *The maximum number of weeks you can receive benefits while you are sick or disabled.*	**Payments may last up to 26 Weeks** You must be sick or disabled for the duration of the waiting period before you can receive a benefit payment.
Coverage Amount	Covers up to 85**% of your weekly income,** up to a maximum benefit of **$993 per week.**
What's covered?	**A variety of conditions and injuries.** Typical claims would include: pregnancy, injuries, joint, cancer and digestive disorders.
Definition of Earnings	**Base Salary** *(excludes commissions and bonuses)*

VOLUNTARY BENEFITS

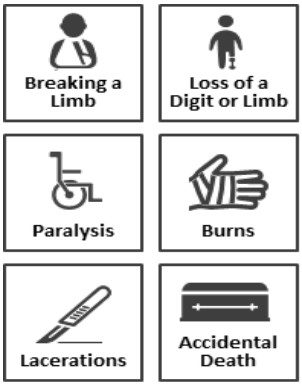
ACCIDENT | **COVERAGE OVERVIEW**

Accident Insurance

A serious injury can cost you a lot of money – not only in medical bills but in things like income from lost work hours. Some injuries are minor, but others are debilitating and require significant medical care. If you get hurt, accident insurance pays you money that you can use to cover personal expenses, bills, and out-of-pocket medical costs.

What's Covered?

Not all accidents are "qualifying injuries." The kinds of accidents that are covered can vary by plan, but accident insurance plans typically cover things like:



If you have a covered injury, accident insurance can help you pay for things like:

- Emergency Room Visits
- Ambulance Transportation
- Emergency Helicopter Transportation
- Hospital Admissions & Per Diem Charges
- Intensive Care & Rehabilitation Unit Care
- Diagnostic Exams
- Follow-up Treatments
- Physical Therapy

	Voluntary Accident Plan
Injuries	
Fractures	Up to $4,500
Dislocations	Up to $3,375
Laceration	Up to $600
Medical Services & Treatment	
Ambulance	$300 Ground / $1,000 Air
Accident Emergency Treatment	$100
Hospital Coverage	
Admission	$1,000
Confinement	$300 a day, up to 15 days
Inpatient Rehab	$100 a day, up to 15 days
Accidental Death	
Employee	$50,000
Spouse	$25,000
Child	$12,500
Dismemberment, Loss & Paralysis	$750 - $50,000 per injury

Bi-Weekly Payroll Deductions	
Employee Only	$4.71
Employee & Spouse	$8.53
Employee & Child(ren)	$11.61
Employee & Family	$15.43

$50 WELLNESS BENEFIT
Per Covered Individual

For screening such as: blood tests, chest x-rays, stress tests, colonoscopies, mammograms, and other tests listed in your policy.

VOLUNTARY BENEFITS

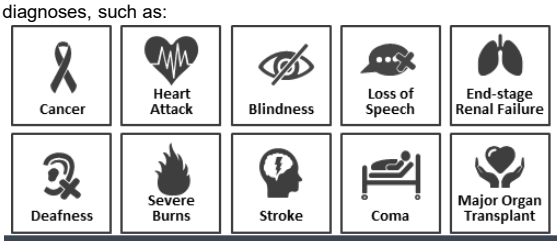
CRITICAL ILLNESS | **COVERAGE OVERVIEW**

Critical Illness Insurance

How would you pay your bills if you were suddenly diagnosed with cancer and couldn't work? Critical illness insurance doesn't' pay your medical bills. It pays you if you're diagnosed with a covered illness. The benefit is paid directly to you and is your choice how to spend it.

What's Covered?

Critical illness can vary widely from one another. Some may focus on a single specific diagnosis, while others may provide you with coverage for a range of possible diagnoses, such as:



Voluntary Critical Illness	
Benefit Amounts Employee Spouse/Child	$10,000 or $20,000 50% of Employee Benefit Amount
Guarantee Issue	Coverage is guaranteed provided (1) the Employee is actively at work and (2) dependents are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage.
Pre-Existing Condition Exclusion (Only applies to late entrants and increases)	Benefits are not payable for a condition which you received medical treatment, consultation, care or services including diagnostic measures in the 3 months just prior to your effective date. Pre-existing conditions are excluded from coverage if the condition begins in the first 12 months after your effective date of coverage.
100% Covered Conditions	Benign Brain Tumor, Invasive Cancer, Coma, Paralysis, Heart Attack, Kidney Failure, Major Organ Transplant, Severe Burn, Stroke
25% Covered Conditions	Non-Invasive Cancer, Infectious Diseases

Bi-Weekly Payroll Deductions with $50 Be Well Benefit

	Employee		Spouse	
Age*	**$10,000**	**$20,000**	**$5,000**	**$10,000**
<25	$1.61	$2.34	$1.24	$1.61
25 – 29	$1.96	$2.99	$1.40	$1.93
30 – 34	$2.44	$4.01	$1.65	$2.44
35 – 39	$2.94	$5.02	$1.91	$2.94
40 – 44	$4.10	$7.33	$2.48	$4.10
45 – 49	$5.94	$11.02	$3.41	$5.94
50 - 54	$8.90	$16.93	$4.88	$8.90
55 – 59	$12.50	$24.13	$6.68	$12.50
60 – 64	$18.08	$35.30	$9.48	$18.08
65 – 69	$26.71	$52.56	$13.79	$26.71
70 – 74	$39.87	$78.87	$20.37	$39.87
75 – 79	$55.47	$110.07	$28.17	$55.47
80 - 84	$76.05	$151.24	$38.46	$76.05
85+	$119.21	$237.54	$60.04	$119.21

**Rates are based on your age as of December 1, 2023*

$50 WELLNESS BENEFIT
Per Covered Individual

For screening such as: blood tests, chest x-rays, stress tests, colonoscopies, mammograms, and other tests listed in your policy.

VOLUNTARY BENEFITS

HOSPITAL INDEMNITY | **COVERAGE OVERVIEW**

Hospital Indemnity

Hospital stays can be expensive and usually unexpected. A Hospital Indemnity plan complements your medical coverage by paying a benefit directly to you for a covered hospital stay. You receive a lump-sum amount to use however you choose. This is independent of what your health plan may cover. You can use it for deductibles or out-of-pocket expenses or to pay for everyday living expenses, like child care or home services.

What's Covered?

Hospital Indemnity pays you for a variety of medical services including but not limited to:

- Hospital admissions
- Hospital confinement (stays up to 365 days)
- Intensive Care Unit (ICU) admission
- ICU confinement (stays up to 30 days)
- Rehabilitation confinement

	LOW PLAN
Inpatient Admission	$1,500
Inpatient Confinement	$200
ICU Admission	$1,500
ICU Confinement	$400
Pre-Existing Condition Limitation (Only applies to late entrants)	Benefits are not payable for a condition which you received medical treatment, consultation, care or services including diagnostic measures in the 3 months just prior to your effective date. Pre-existing conditions are excluded from coverage if the condition begins in the first 12 months after your effective date of coverage.

Bi-Weekly Payroll Deductions	
Employee Only	$9.63
Employee & Spouse	$22.19
Employee & Child(ren)	$14.47
Employee & Family	$27.03

EXTRAS

VALUE ADDED SERVICES | MEMBER DISCOUNTS

SECURE TRAVEL ASSISTANCE

This travel assistance program provides special assistance for emergency medical, financial, legal and communications needs when you or a covered dependent are traveling at least 100 miles from home. This service is included in the Unum Basic Life Insurance program.

NEED MORE INFO?
Assist America
US/Canada: 1.800.872.1414
Other Locations: +609.986.1234
Email: medservices@assistamerica.com

LIFE PLANNING FINANCIAL & LEGAL RESOURCES

When a loved one is terminally ill, or passes away, you may need help with the personal, financial and legal decisions that need to be made. Support is always available when you are protected by Unum Group Life Insurance.

When a life claim is submitted and approved, a specially trained consultant will reach out to you or your beneficiary to provide support. Each consultant holds a Master's degree in the mental health field, and is highly skilled at assisting those who need help dealing with the emotional challenges of a terminal illness or the loss of a loved one.

NEED MORE INFO?
UNum
1.800.422.5142
www.members.healthadvocate.com
(Enter Unum – Life Planning)

EMPLOYEE ASSISTANCE PROGRAM (EAP)

This service is included in the Unum Long Term Disability program.

Life brings new questions and challenges every day. Living a productive and fulfilling life requires a healthy mind and a healthy body. Whether you're looking for child care or help with an older relative, trying to manage your personal finances, or coping with a health issue, the EAP is a confidential, third-party administrator, and is available for you and your dependents should you need assistance whenever you need it. From help with a relationship to managing overload at work, the EAP can help you with almost any personal or work-related issues. You will be able to have up to 3 face to face visits and unlimited telephonic counseling.

This is a confidential, voluntary and professional program and is intended to be a short term resource. This EAP is administered and provided by Unum and is available to you and your dependents at no additional cost with your Long Term Disability plan.

NEED MORE INFO?
Unum
1.800.854-1446
www.unum.com/lifebalance

VISION DISCOUNTS

You will receive the following additional discounts if you're enrolled in one of the EyeMed vision plans and go to an in-network provider:

- 40% off a complete pair of prescription eyeglasses
- 20% off non-prescription sunglasses
- 15% off the retail price or 5% off the promotional price of Laser Vision Correction
- 20% off the retail price of any other add-ons or services
- 40% off hearing exams and a low price guarantee on discounted hearing aids

NEED MORE INFO?
EyeMed
www.eyemed.com

REQUIRED NOTICES

Federal regulations require employers to provide certain notifications and disclosures to all eligible employees. This section of your benefit guide is dedicated to those disclosures for January 1, 2024 thru December 31, 2024. If you have any questions or concerns, please contact your plan administrator as follows:

Luz Morales
609-807-3001
lmorales@envisionbp.com

FAMILY MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act (FMLA) of 1993 was designed to provide eligible employees with up to 12 workweeks per year of job-protected leave to address critical personal and family matters. It is the policy of **Envision Building Products, LLC** and its U.S. subsidiaries to provide eligible employees with a leave of absence in accordance with the provisions of FMLA.

You are eligible for an FMLA leave of absence under this policy if you meet the following requirements:

- You have completed at least 12 months of employment (need not be consecutive, but employment prior to a continuous break in service of seven or more years may not be counted).
- You have worked at least 1,250 hours during the 12-month period immediately preceding the commencement of the requested leave.
- You are employed at a work site where 50 or more employees are employed by the Company within 75 miles of that work site ("eligible employees").

To the extent permitted by law, leave taken pursuant to FMLA will run concurrently with Workers' Compensation, Short Term Disability, and all other Company leave policies.

The *"break in service cap"* doesn't apply if it:

- is attributable to fulfillment of National Guard or Reserve military service obligations; or
- is addressed in a written agreement, including a collective bargaining agreement, that expresses the employer's intent to rehire the employee after the break in service, such as a break to pursue education or raise children.

Procedure for Applying for FMLA Leave

If you desire and require an FMLA leave of absence under this policy, you must notify your manager and Sharleen Rodriguez at least 30 calendar days in advance of the start of the leave when the need for such leave is reasonably foreseeable (as in the case of a birth, the placement for adoption of a son or daughter, or a planned medical treatment for a serious health condition).

However, if the date of the birth, placement, or planned medical treatment requires leave to begin in less than 30 calendar days, you must provide such notice to the aforementioned parties as soon as it is both possible and practicable. Failure to provide timely notice may result in a delay or denial of FMLA leave.

IRS CODE SECTION 125

Premiums for medical, dental, vision insurance, and/or certain supplemental plans and contributions to FSA accounts (Health Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-tax to the extent permitted. Under Section 125, changes to an employee's pre-tax benefits can be made ONLY during the Open Enrollment period unless the employee or qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event.

Under certain circumstances, employees may be allowed to make changes to benefit elections during the plan year, if the event affects the employee, spouse, or dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125. Any requested changes must be consistent with and on account of the qualifying event.

Examples Of Qualifying Events:

- Legal marital status (for example, marriage, divorce, legal separation, annulment);
- Number of eligible dependents (for example, birth, death, adoption, placement for adoption);
- Employment status (for example, strike or lockout, termination, commencement, leave of absence, including those protected under the FMLA);
- Work schedule (for example, full-time, part-time);
- Death of a spouse or child;
- Change in your child's eligibility for benefits (reaching the age limit);
- Change in your address or location that may affect the coverage for which you are eligible;
- Significant change in coverage or cost in your, your spouse's or child's benefit plans;
- A covered dependent's status (that is, a family member becomes eligible or ineligible for benefits under the Plan);
- Becoming eligible for Medicare or Medicaid; or
- Your coverage or the coverage of your Spouse or other eligible dependent under a Medicaid plan or state Children's Health Insurance Program ("CHIP") is terminated as a result of loss of eligibility and you request coverage under this Plan no later than 60 days after the date the Medicaid or CHIP coverage terminates; or
- You, your spouse or other eligible dependent become eligible for a premium assistance subsidy in this Plan under a Medicaid plan or state CHIP (including any waiver or demonstration project) and you request coverage under this Plan no later than 60 days after the date you are determined to be eligible for such assistance.

Qualifying Events, which ARE NOT available for a Health Care FSA program, if applicable:

- Coverage by your spouse or other covered dependent permitted under the spouse's or covered dependent's employer's benefit plan due to a Change Event;
- The availability of benefit options or coverage under any of the Benefit Programs under the Plan (for example, an HMO is added to or deleted from the Medical Program);
- An election made by your spouse or other covered dependent during an open enrollment period under your spouse's or other covered dependent's employer's benefit plan that relates to a period that is different from the Plan Year for this Plan (for example, your spouse's open enrollment period is in July and your spouse changes coverage); or
- The cost of coverage during the Plan Year, but only if it is a significant increase or decrease.

Available for Dependent Care FSA Only, If applicable:

- Your dependent care provider or cost of dependent care (a significant increase or decrease).

Additional Change Events For Health Care Options:

In addition to the above Change Events, you may also change elections for the Medical, Dental, Vision and Health Care FSA Programs if:

- You, your spouse, or other covered dependent become eligible for continuation coverage under COBRA or USERRA;
- A judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order), is entered by a court of competent jurisdiction that requires accident or health coverage for your child;
- You, your spouse, or other covered dependent become enrolled under Part A, Part B, or Part D of Medicare or under Medicaid (other than coverage solely with respect to the distribution of pediatric vaccines); or
- You, your spouse, or other covered dependent become eligible for a Special Enrollment Period.

HEALTH COVERAGE REMINDER

The Patient Protection and Affordable Care Act (PPACA) requires most individuals to have minimum essential health coverage or pay a penalty. You may obtain coverage through **Envision Building Products, LLC** or through the Marketplace.

- Depending on your income and the coverage offered by **Envision Building Products, LLC**, you may be able to obtain lower cost private insurance in the Marketplace.
- If you buy insurance through the Marketplace, you may lose any employer contribution to your health benefits.

Visit **www.healthcare.gov** for Marketplace information.

WOMEN'S HEALTH & CANCER RIGHTS ACT (WHCRA)

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

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

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

SHINGLES VACCINE

Public Act 96-978 is an Illinois state mandate that requires the coverage of a shingles vaccine that is approved by the Food and Drug Administration (FDA) if the vaccine is ordered by a licensed physician, and the member is 60 years of age or older.

REQUIRED NOTICES

SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if **Envision Building Products, LLC** stops contributing toward your or your dependents' other coverage). However, you must enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from or determined to be eligible for such assistance.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact Angie Papavasilion .

MICHELLE'S LAW NOTICE

The health plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary, and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, contact your Human Resource Department as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

THE GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

Genetic Information Non-Discrimination Act (GINA) prohibits discrimination by health insurers and employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions: prohibits the use of genetic information in making employment decisions; restricts the acquisition of genetic information by employers and others; imposes strict confidentiality requirements; and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

NOTICE OF ELIGIBILITY FOR HEALTH PLANS RELATED TO MILITARY LEAVE

If you take a military leave, the Uniformed Services Employment and Reemployment Rights Act (USERRA) provides the following rights:

- If you take a leave from your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage at your cost for you and your dependents for up to 24 months during your military service; or
- If you don't elect to continue coverage during your military service, you have the right to be reinstated in the Plan when you are reemployed within the time period specified by USERRA, without any additional waiting period or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

The Plan Administrator can provide you with information about how to elect Continuation Coverage Under USERRA.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

The Act, passed into law October 3, 2008, amends the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code (Code) and the Public Health Service Act (PHSA). MHPAEA requires that group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

AUTISTM SPECTRUM DISORDERS

This law was effective December 12, 2008. It requires coverage for children under the age of 21 for the diagnosis and treatment of autism spectrum disorders. The Affordable Care Act bans annual caps on benefits for "essential benefits" such as mental health and behavioral services. Coverage cannot be subject to a less favorable provision that apply to other physical illnesses. An autism spectrum disorder means pervasive development disorders (autism, Asperger's, and pervasive developmental disorders not otherwise specified). Diagnosis can be made by a licensed physician or a licensed clinical psychologist who is experienced in diagnosing autism spectrum disorders. Treatment includes psychiatric care, psychological care, habilitative and rehabilitative care, therapeutic care (including speech, physical, behavioral, and occupational therapies).

BREAK TIME FOR NURSING MOTHERS

This requirement became effective with the signing of the Affordable Care Act on March 23, 2010. It requires employers to provide reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth each time such employee has need to express the milk. Employers are also required to provide a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk. If the space is not dedicated to the nursing mother's use, it must be available when needed in order to meet the statutory requirement. The FLSA (Fair Labor Standards Act) requirement of break time for nursing mothers to express breast milk does not preempt State laws that provide greater protections to employees (for example, providing compensated break time, providing break time for exempt employees, or providing break time beyond 1 year after the child's birth).

NATIONAL HEALTH CARE REFORM

The Affordable Health Care Act was signed into law on March 23, 2010. Key provisions include:

- Preventive care services with no cost sharing
- No lifetime limits on essential benefits
- No annual limits on essential benefits
- Revised appeal process
- Medicare Part D "donut hole" rebate
- Dependent child coverage to age 26
- No pre-existing conditions exclusions for enrollees
- Restricted recissions
- W-2 reporting (HHS delayed implementation and will issue further guidance)
- Non-grandfathered health plans include these services without cost-sharing, subject to the exception described below for religious employers.
  Well-woman visits - Includes an annual well-woman preventive care visit for adult women to obtain the recommended preventive services, and additional visits if women and their providers determine they are necessary.
- Gestational diabetes screening - Screening for women 24-28 weeks pregnant, and those at high risk of developing gestational diabetes.
- Human papillomavirus (HPV) DNA testing for women age 30 and older - Women who are age 30 or older will have access to high-risk HPV DNA testing every three years, regardless of Pap smear results.
- Sexually transmitted infection (STI) counseling - Sexually active women will have access to annual counseling on STIs.
- Human immunodeficiency virus (HIV) screening and counseling - Sexually active women will have access to annual screening and counseling on HIV infections.

REQUIRED NOTICES

NATIONAL HEALTH CARE REFORM Cont'd

- FDA-approved contraception methods and contraceptive counseling - Women will have access to all FDA-approved contraceptive methods, sterilization procedures and patient education and counseling.
- Breastfeeding support, supplies and counseling - Pregnant and postpartum women will have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment.
- Domestic violence screening and counseling - Screening and counseling for interpersonal and domestic violence.

Group health plans sponsored by certain religious employers and group health insurance coverage in connection with such plans, are exempt for the requirement to cover contraceptive services. A religious employer is one that: (1) has the inculcation of religious values as its purpose; (2) primarily employs persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a non-profit organization under Internal Revenue Code section 6033(a)(1) and section 6033(a)(3)(A)(I) or (iii).

MEDICARE PART D CREDITABLE COVERAGE NOTICE

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 **Envision Building Products, LLC** and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers 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. Prescription drug coverage offered by the group health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current coverage through **Envision Building Products, LLC** will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at **http://www.cms.hhs.gov/CreditableCoverage/,** which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current group health coverage through **Envision Building Products, LLC,** be aware that you and your dependents will be able to get this coverage back, subject to the terms and requirements of such group medical plan.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage:
Contact the HR Administrator.

NOTE: 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 changes. You also may request a copy of this notice at any time.

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 are eligible for health coverage from **Envision Building Products, LLC**, 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 are not 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, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877- KIDS NOW** or go to **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can 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 **Envision Building Products, LLC** plan, **Envision Building Products, LLC** must allow you to enroll in **Envision Building Products, LLC** plan if you are not 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 **Envision Building Products, LLC** plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866- 444-EBSA (3272).**

If you live in one of the following States {AL, AK, AR, CO, FL, GA, IN, IA, KS, KY, LA, ME, MA, MN, MO, MT, NE, NV, NH, NJ, NY, NC, ND, OK, OR, PA, RI, SC, SD, TX, UT, VT, VA, WA, WV, WI, and WY}, you may be eligible for assistance paying Envision Building Products, LLC health plan premiums.

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:
U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
P: 866.444.EBSA (3272)
U.S. Department and Human Services Center for Medicare & Medicaid Services
www.cms.hhs.gov
P: 877.267.2323 Menu Option 4, Ext. 61565

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

REQUIRED NOTICES

COBRA COVERAGE

Federal law requires **Envision Building Products, LLC** to offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end.

To Qualify For COBRA Coverage:

Employees – As an employee of **Envision Building Products, LLC** covered by our health plans**,** you have the right to elect this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

Spouses – As the spouse of an employee covered by our health plans**,** you have the right to choose continuation coverage for yourself if you lose group health coverage under **Envision Building Products, LLC's health plans,** for any of the following reasons:

- The death of your spouse who was a **Envision Building Products, LLC** employee;
- A termination of your spouse's employment (for reasons other than gross misconduct);
- A reduction in your spouse's hours of employment;
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare.

Dependent Children

Dependent children of **Envision Building Products, LLC** employees covered by our health plans, have the right to continuation coverage if group health coverage under our plans, is lost for any of the following reasons:

- The death of a parent who was a **Envision Building Products, LLC** employee;
- The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with **Envision Building Products, LLC;**
- Parents' divorce or legal separation;
- A parent who is an employee of **Envision Building Products, LLC** becomes entitled to Medicare; or
- The dependent ceases to be a "dependent child" under the terms of our health plans.

Please note that it is the employee's responsibility to notify the HR Administrator of any communication regarding loss of coverage and communication regarding such between the employee and the insurance carrier. Please note that employees must also provide notice of other events (e.g., divorce) to Angie Papavasilion .

Continuation of Coverage Rights Under COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more 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.

You may have other options available to you when you lose group health coverage.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of- pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.
- If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- 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 entitled to 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 lose coverage under the Plan because of the following qualifying events:
- 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 entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plans as a "dependent child."

When Is COBRA Continuation 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. **Envision Building Products, LLC** must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all 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.

How Is COBRA Continuation 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 that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension Of 18-month Period Of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

Second Qualifying Event Extension Of 18-month Period Of Continuation Coverage

If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If you have questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa. *(Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)*

For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Administrator Informed Of Address Changes*

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

REQUIRED NOTICES

NOTICE OF HIPAA PRIVACY PRACTICES

The privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) became effective April 14,2003. These federal regulations require covered entities, such as health plans, to provide plan participants with a notice of privacy practices describing the health-related information that is collected, how it is used, and the ways in which the regulations permit it to be disclosed. These privacy notices also provide information on a participant's right to access, review and, if necessary, to have this information amended.

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

"We," "us", and "Plan" refer to all the health benefit plans and programs presented herein. "Plan Sponsor" refers to **Envision Building Products, LLC.** "You" or "yours" refers to individual participants in the Plans.

PHI is information that may identify you and that relates to past, present, or future health care services provided to you, payment for health care services provided to you, or your physical or mental health or condition.

Envision Building Products, LLC's Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Plan's uses and disclosures of Protected Health Information (PHI);
2. Your privacy rights with respect to your PHI;
3. The Plan's duties with respect to your PHI;
4. Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. The person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

We are required by the Health Insurance Portability and Accountability Act (HIPAA) to:

1. Maintain the privacy of your PHI;
2. Provide you with certain rights with respect to your PHI;
3. Provide you with this Notice of our legal duties and privacy practices regarding your PHI; and
4. Abide by the terms of this Notice as it may be updated from time to time.

We protect your PHI from inappropriate use or disclosure. Our employees and those of our Business Associates are required to protect the confidentiality of PHI. They may look at your PHI only when there is an appropriate reason to do so, such as to determine coordination of benefits or services. We will not disclose your PHI to anyone for marketing purposes.

USES AND DISCLOSURES OF PHI

Primary Uses and Disclosures of PHI: The main reasons for which we may use and may disclose your PHI are in order to administer our health benefit programs effectively and to evaluate and process requests for coverage and claims for benefits.

The following describe these and other uses and disclosures together with some examples:

Treatment*: Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. We may disclose your PHI to health care providers to provide you with treatment. For example, we might respond to an inquiry from a hospital about your eligibility for a particular surgical procedure.

Payment*:Payment refers to our activities in collecting premiums and paying claims for health care services you receive. We may use your PHI or disclose it to others for these purposes. For example, if you had insurance coverage from a spouse's employer, we might disclose your PHI to the other insurer to determine coordination of benefits or services. Payment also refers to the activities of a health care provider in obtaining reimbursement for services. We may disclose your PHI to a provider for this purpose.

Health Care Operations Purposes* -

1. We may use your PHI or disclose it to others for quality assessment and improvement activities.
2. We may use your PHI or disclose it to others for activities relating to improving health or reducing health care costs, development of health care procedures, case management, and care coordination.
3. We may use your PHI or disclose it to others for the purpose of informing you or a health care provider about treatment alternatives.
4. We may use your PHI or disclose it to others for the purpose of reviewing the competence, qualifications, or performance of health care providers, or conducting training programs.
5. We may use your PHI or disclose it to others for accreditation, certification, licensing, or credentialing activities.
6. We may use your PHI or disclose it to others in the process of contracting for health benefits or insurance covering health care costs.
7. We may use your PHI or disclose it to others for purposes of reviewing your medical treatment, obtaining legal services, performing audits or obtaining auditing services, and detecting fraud and abuse.
8. We may use your PHI or disclose it to others in our business management, planning, and administrative activities. As an example, we might use your PHI in the process of analyzing data about treatment of certain conditions to develop a list of preferred medications.

Business Associates: We contract with various individuals and entities (Business Associates) to perform functions on behalf of the Plans or to provide certain services. To perform these functions, our Business Associates may receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to safeguard your PHI.

Plan Sponsor: We and our Business Associates may also disclose PHI to the Plan Sponsor without your written authorization in connection with payment, treatment, or health care operations purposes or pursuant to a written request signed by you. Such disclosures may only be made to the individuals authorized to receive such information. If PHI is disclosed to the Plan Sponsor for these purposes, the Plan Sponsor agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law.

Other Covered Entities: Envision Building Products, LLC (including the insured plans) together are called an "organized health care arrangement. "The Plans may share PHI with each other for the health care operations purposes of the organized health care arrangement.

**The amount of health information used, disclosed, or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purpose, as defined under the HIPAA rules.*

OTHER POSSIBLE USES AND DISCLOSURES OF PHI

In addition to using and disclosing your PHI for treatment, payment, and health care operations purposes, we may (and are permitted) to use or disclose it in the following circumstances:

To Persons Involved in Care and for Notification Purposes: We may disclose PHI to a family member, relative, close personal friend, or any other person identified by you, provided that the PHI is directly relevant to that person's involvement with your care or payment related to your care. In addition, we may use or disclose PHI to notify a member of your family, your personal representative, or another person responsible for your care of your location, your general condition, or your death.

In Regard to Abuse, Neglect, or Domestic Violence: In certain circumstances, we may disclose your PHI to a government authority that is authorized to receive reports of cases of abuse, neglect, or domestic violence.

To Coroners, Medical Examiners, and Funeral Directors: We may disclose PHI to coroners and medical examiners for the purpose of identifying a deceased person, determining a cause of death, or other purposes authorized by law. We may disclose PHI to funeral directors to enable them to carry out their duties.

For Public Health Activities: We may disclose PHI to public authorities for the purpose of preventing or controlling disease, injury, or disability. Under some circumstances, when authorized by law, we may disclose PHI to an individual who is at risk of contracting or spreading a contagious disease or condition. We also may disclose PHI to appropriate parties for the purpose of activities related to the quality, safety, or the effectiveness of products regulated by the U.S. Food and Drug Administration.

To Avert a Threat to Health or Safety: We may, under certain circumstances, disclose PHI to avert a serious threat to the health or safety of a person or the general public.

Organ and Tissue Donations: We may, under certain circumstances, disclose PHI for purposes of organ, eye, or other medical transplants or tissue donation purposes.

To Comply with Workers' Compensation Laws: We may disclose your PHI to the extent necessary to comply with laws relating to Workers' Compensation or other similar programs.

For Law Enforcement and National Security Purposes: In certain circumstances, we may disclose PHI to appropriate officials for law enforcement purposes; for example, if it is required by law or legal process. In addition, we may disclose your PHI if you are or were armed forces personnel or to authorized federal officials for conducting national security and intelligence activities.

In Connection with Legal Proceedings: In certain cases, we may disclose PHI in connection with the legal proceedings of courts or governmental agencies. For example, we may disclose your PHI in response to a subpoena for such information but only after certain conditions required by HIPAA are met.

For Health Oversight Activities: We may disclose PHI to a governmental agency authorized by law to oversee the health care system, compliance with civil rights laws, or government benefit. Health oversight activities include audits, inspections, investigations, or legal proceedings.

Military Personnel: If you are in the armed forces, we may disclose your PHI for activities that military authorities consider necessary to the accomplishment of a mission.

Inmates: If you are incarcerated, we may disclose your PHI to appropriate authorities who tell us they need it for your health care, your safety, the health or safety of other persons, or general administrative purposes.

Research: Under certain circumstances, we may disclose PHI for research purposes.

Health Information: We may contact you with information about treatment alternatives and other health-related benefits and services.

As Required by Law: We may disclose your PHI when required to do so by federal, state, or local law.

REQUIRED DISCLOSURES OF PHI

The following is a description of disclosures we are required by law to make:

Disclosures to the Secretary of the U.S. Department of Health & Human Services: We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining compliance with HIPAA.

Disclosure to You: We are required to disclose to you most of your PHI. We will also disclose your PHI to an individual whom you have designated as your personal representative. However, before we can disclose your PHI to such person, you must submit a written notice of his/her designation along with documents supporting his/her qualification (such as a power of attorney). In limited situations HIPAA permits us to elect not to treat the person as your personal representative if we have reasonable belief that it could endanger you.

OTHER USES AND DISCLOSURES OF YOUR PHI WITH AUTHORIZATION

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. You may revoke an authorization at any time by providing written notice to us. We will honor a request to revoke as of the day it is received and to the extent that we have not already used or disclosed your PHI in reliance on the authorization. To obtain an Authorization for Release of Information, call **the HR Administrator.** You may revoke an authorization by contacting the Health Information Privacy Officer identified at the end of this Notice.

REQUIRED NOTICES

NOTICE OF HIPAA PRIVACY PRACTICES CONTINUED

YOUR RIGHTS

Right to Request Restrictions on Uses and Disclosure

You may ask us to restrict uses and disclosures of your PHI for treatment, payment, or health care operations purposes, or to restrict disclosures to family members, relatives, friends, or other persons identified by you who are involved in your care or payment for your care, or to restrict disclosures for notification purposes. However, we are not generally required to comply with your request for restrictions except in those situations where the requested restriction relates to the disclosure to the Plan for purposes of carrying out payment or health care operations (and not for treatment), and the PHI pertains solely to a health care item or service that was paid out of pocket in full. You may exercise this right by contacting the Health Information Privacy Officer identified at the end of this Notice who will provide you with additional information including what information is required to make a restriction request.

Right to Inspect, Copy, and Amend Your PHI

As long as we maintain records containing your PHI, you have a right to inspect and copy such information. These rights are subject to certain limitations and exceptions. For example, if the requested information contains psychotherapy notes or may endanger someone, it may not be available. You may request a review of any denial to access. If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. If you believe your PHI held and created by us is incorrect or incomplete, you may request that we amend your PHI. You will be required to provide the reason the amendment is necessary. Requests for access to your PHI or amendment of your records should be in writing and directed to the Health Information Privacy Officer identified at the end of this Notice.

Right to a List of Disclosures

You have a right to an accounting of certain disclosures of your PHI by us. The accounting will not include those items which are not required to be provided such as disclosures made at your request or disclosures made for treatment, payment, or health care operations. A request for a list of disclosures should be directed to the Health Information Privacy Officer identified at the end of this Notice.

Right to Request Confidential Communications

We will accommodate a reasonable request by you to receive communications from us by alternative means or at an alternative location if you believe that disclosure of your PHI could pose a danger to you. For example, you may request that we only contact you by mail or at work. Requests for confidential communications should be in writing and directed to the Health Information Privacy Officer identified at the end of this Notice.

Right to be Notified of a Breach

You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured PHI.

Right to Receive Paper Copy

You have the right to receive a paper copy of this Notice from the Plan upon request even if you have previously agreed to receive copies of this Notice electronically. Requests for a paper copy should be in writing and directed to the Health Information Privacy Officer identified at the end of this Notice.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI we maintain. If we change this Notice, you will receive a new Notice. Active employees will receive the Notice by distribution in the workplace; inactive employees (including retirees) will receive the Notice by mail.

Complaints: If you believe that your privacy rights have been violated, you may complain to us in writing at the location described below under "Health Information Privacy Officer" or with the office for Civil Rights of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20211. You will not be retaliated against for filing a complaint.

Health Information Privacy Officer: You may exercise the rights described in this Notice by contacting the office identified below, which will provide you with additional information.

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 **Envision Building Products, LLC**.

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 **Envision Building Products, LLC** 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 **Envision Building Products, LLC** that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in **Envision Building Products, LLC'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 **Envision Building Products, LLC** does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from **Envision Building Products, LLC** 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 **Envision Building Products, LLC** provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by **Envision Building Products, LLC**, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by **Envision Building Products, LLC**, please check your summary plan description or contact **Angie Papavasilion .**

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by **Envision Building Products, LLC**. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name Envision Building Products, LLC	4. Employer Identification Number (EIN) 87-3417955	
5. Employer Address **53 Eby Chiques Road**	6. Employer Phone Number **(609) 807-3001**	
7. City **Mount Joy**	8. State **PA**	9. Zip Code 17552
10. Who Can We Contact About Employee Health Coverage **Luz Morales**		
11. Contact Phone Number **(609) 807-3001**	12. Contact Email Address **lmorales@envisionbp.com**	

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

As your employer, we offer a health plan to some employees. As of January 1, 2019, eligible employees are:

Employer-Sponsored Health Coverage Provided for Employees - Employees who average or are reasonably expected to average 30 hours or more per week are eligible for coverage. Please refer to your Summary Plan Description of the applicable plan or contact the HR Administrator or more information on the plan's eligibility rules.

With respect to dependents, we do offer coverage to some dependents. As of January 1, 2019, eligible dependents are:

Employer-Sponsored Health Coverage Provided to Employees - Spouses, Domestic Partners, Parties to a Civil Union, Children Up To Age 26, and Disabled Children Age 26 or Older. Please refer to your Summary Plan Description or contact the HR Administrator for more information on the plan's definition of Spouse, Child(ren), and Disabled Child(ren).

The offered coverage is intended to meet the minimum value standard.

Even if **Envision Building Products, LLC 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, www.healthcare.gov will guide you through the process.

GLOSSARY OF TERMS

Beneficiary – A person designated by you, the participant of a benefit plan, to receive the benefits of the plan in the event of the participant's death.

- **Primary Beneficiary –** A person who is designated to receive the benefits of a benefit plan in the event of the participant's death
- **Contingent Beneficiary** – A person who is designated to receive the benefits of a benefit plan in the event of the Primary Beneficiary's death

Charges – The term "charges" means the actual billed charges. It also means an amount negotiated by a provider, directly or indirectly, if that amount is different from the actual billed charges.

Coinsurance – The percentage of charges for covered expenses that an insured person is required to pay under the plan (separate from copayments)

Deductible – The amount of money you must pay each year to cover eligible expenses before your insurance policy starts paying.

Dependents – Dependents are you:

- Lawful spouse through a marriage that is lawfully recognized.
- Dependent child (married or unmarried) under the age of 26 including stepchildren and legally adopted children.

Proof of relationship documentation will be required in order to add dependents to your plan(s). Employees will receive request for documentation.

Emergency Services – Medical, psychiatric, surgical, hospital, and related health care services and testing, including ambulance service, that are required to treat a sudden, unexpected onset of a bodily injury or serious sickness that could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones.

The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital, or the final diagnosis – whichever reasonably indicated an emergency medical condition – will be the basis for the determination of coverage provided such symptoms reasonably indicate an emergency.

Evidence of Insurability (EOI) – Proof that you are insurable based on the requirements of the insurance carrier. *For example, the results of a blood test or a doctor's signature on a form may be required for you to be covered by/for Optional Life insurance.*

Explanation of Benefits — The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs are your responsibility.

In-Network – The term "in-network" refers to health care services or items provided by your Primary Care Physician (PCP) or services/items provided by another participating provider and authorized by your PCP or the review organization. Authorization by your PCP or the review organization is not required in the case of mental health and substance abuse treatment other than hospital confinement solely for detoxification.

Emergency Care that meets the definition of "emergency services" and is authorized as such by either the PCP or the review organization is considered in-network.

Out-of-Network - The term "out-of-network" refers to care that does not qualify as in-network.

Maximum Out of Pocket — The most money you will pay during a year for coverage. It includes deductibles, copayments and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

Medically Necessary/Medical Necessity – Required to diagnose or treat an illness, injury, disease, or its symptoms; in accordance with generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site, and duration; not primarily for the convenience of the patient, physician, or other health care provider; and rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Participating Provider – A hospital, physician, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

Post-Tax – An option to have the payment to your benefits deducted from your gross pay after your taxes have been withheld. Therefore, your tax contributions will be calculated based on a higher amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a higher amount.

Pre-Tax – An option to have the payment to your benefits deducted from your gross pay before your taxes have been withheld. Therefore, your tax contributions will be calculated based on a lesser amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a lesser amount.

Primary Care Dentist (PCD) – The term "Primary Care Dentist" means a dentist who (a) qualifies as a participating provider in general practice, referrals, or specialized care; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for dental care for you or any of your insured dependents.

Primary Care Physician (PCP) – The term "Primary Care Physician" means a physician who (a) qualifies as a participating provider in general practice, obstetrics/gynecology, internal medicine, family practice, or pediatrics; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for medical care for you or any of your insured dependents.

Proof of Relationship Documentation – Documents that show a dependent is lawfully your dependent. Documents can include marriage certificates, birth certificates, adoption agreements, previous years' tax returns, court orders, and/or divorce decrees showing your or your spouse's responsibility for the dependent.

IMPORTANT CONTACT INFORMATION

PROVIDER	CONTACT INFORMATION
Highmark BCBS **Medical** **HDHP Plan/Group #106233- 07, 09** **PPO Plan/Group #107610- 86, 88**	See back of ID card www.highmarkblueshield.com
Delta Dental of PA **Dental** **Plan/Group #22070**	(800) 932-0783 www.deltadentalins.com
EyeMed **Vision** **Plan/Group #1041333**	(866) 939-3633 www.eyemed.com
Unum **Life/STD & LTD Plan/Group #919369** **EE Voluntary Life/AD&D (EE/SP/CH): #919370** **EE Voluntary Critical Illness: #919372** **EE Hospital: #919373** **EE Voluntary Accident: #919371**	(866) 679-3054 www.unum.com
Unum **Employee Assistance Plan (EAP)**	(800) 854-1446 www.unum.com/lifebalance
Unum **Travel Assistance**	US/Canada: (800) 872.1414 Other Locations: +609.986.1234 Email: medservices@assistamerica.com
PNC Bank **Health Savings Accounts**	(800) 345-3806 www.highmarkblueshield.com
Benecon **Flexible Spending Accounts**	(833) 738-6729 cdhservices@benecon.com

Have Questions?

Please see the chart above for provider customer service phone numbers and website addresses.

If you need any other assistance, contact **the HR Administrator at 609-807-3001 or lmorales@envisionbp.com**.

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