
# 2026 Associate Benefits Guide

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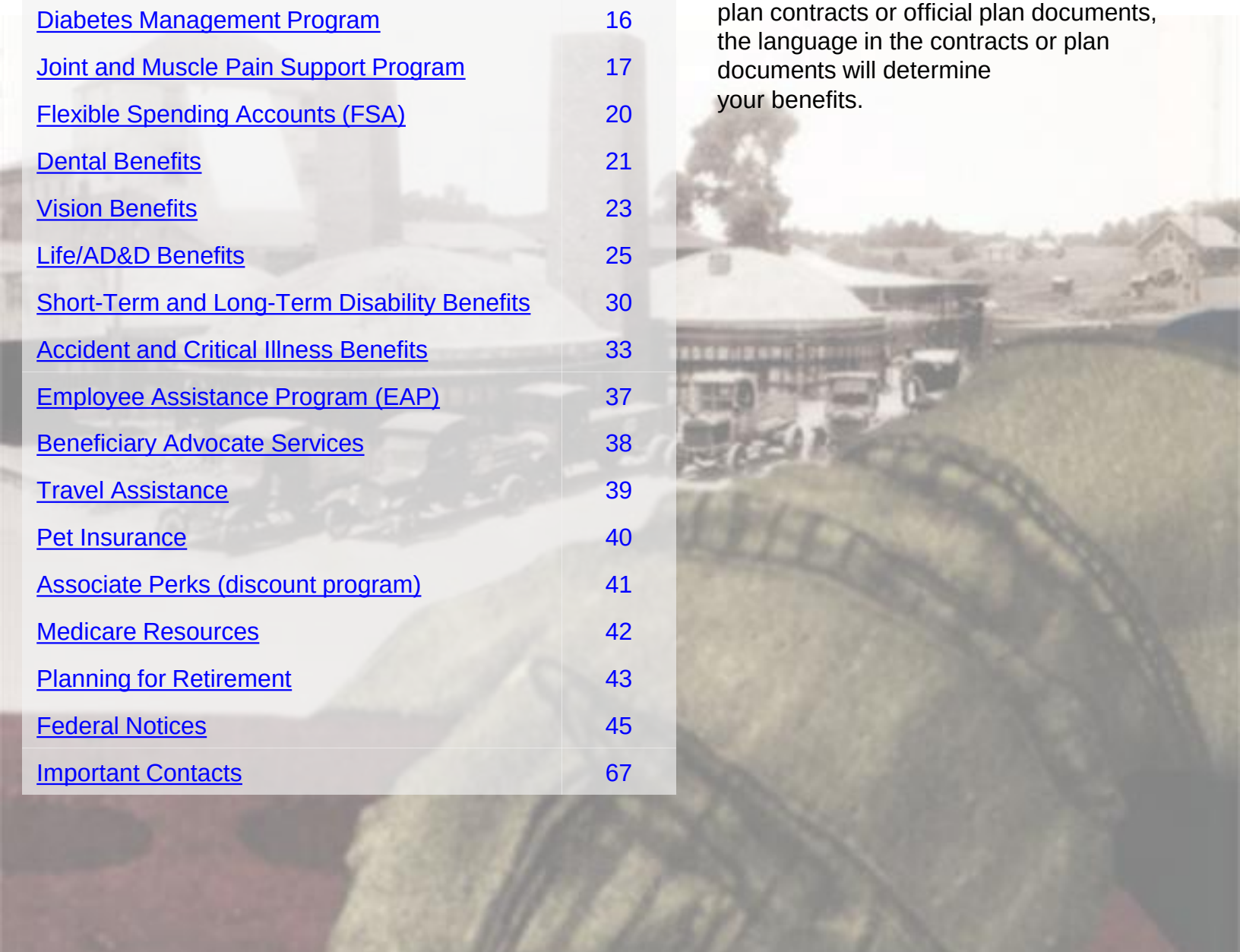
At Acme Brick, we owe our success to you, our hardworking and dedicated associates. In turn, we are pleased to offer you a comprehensive, market-competitive benefits program that offers more choices that fit your life and support your diverse and unique needs — both at work and home.

Benefit plan summaries provided in this guide are intended to provide an overview of the policy. Full terms of the policy can be found in the policy certificate. A copy of the policy certificate(s), is available by request at HR@brick.com.

If there is any discrepancy between this summary and the language in the benefit plan contracts or official plan documents, the language in the contracts or plan documents will determine your benefits.



**ACME BRICK COMPANY**
*a Berkshire Hathaway company*

Ed Watson
ewatson@brick.com
President and CEO

November 1, 2025

Dear Fellow Acme Brick Associates,

Your HR and Senior Leadership teams desire to **Make Acme a Great Place to Work**, where you can have a career, not just a job, keep each other safe, and feel that you are our Greatest Asset.

One of the ways we work to accomplish this is by continuing to refine and expand our associate benefit program to support you and your loved ones. We strive to build an affordable solution that protects you and your family's physical, emotional, and financial health. We are quickly approaching our annual Open Enrollment period, and I wanted to provide you with some information that you can use as you make decisions regarding your healthcare plan choices for 2026.

## 2026 Benefit Changes

We look forward to welcoming Prudential as our new vendor for disability, life, ad&d, and voluntary benefits (group accident & critical illness).

There are no significant benefit changes for 2026, however we want to emphasize the benefits that are already in place and encourage you to take advantage of them.

Livongo - Diabetes Management Program
Annual Physical
Nicotine Cessation Program
Teladoc

These benefits are free to all associates who are enrolled in Acme's medical plan. By participating in these programs, you can improve your personal health, potentially saving you money as well as assisting in lowering the total cost of healthcare.

## 2026 Premiums

While we use Blue Cross/ Blue Shield of Texas ("BCBS/TX") to administer our medical plan, Acme is self-insured. With healthcare and prescription costs continuing to rise in 2025, Acme's plan costs also increased during the year. Projections are that healthcare costs will increase even more in 2026 (by roughly $1 million) and some of the increase will, unfortunately, be passed on to our associates. The Gold plan is the costliest and has most of the higher cost claims, so we had to increase its premiums more than the other two plans.

We are also passing on a higher premium cost to associates who are enrolled in the "Standard" rate for all three plans. This is because associates who are enrolled at the "Standard" rates are tobacco users or do not fulfill the "Select" rate requirement to get an annual physical.

Ed Watson
ewatson@brick.com
President and CEO

I strongly recommend that anyone who has been enrolled at the "Standard" rate should save money by choosing the "Select" rate, getting an annual physical, and stopping the use of tobacco. This might allow you to live a longer, healthier life and help keep our healthcare costs lower for all associates.

The Cigna Dental PPO plan lifetime maximum for dependent child orthodontia is increasing from $1,000 to $2,000.

There will not be a cost increase to the other health plans:

Dental
Vision
Short-term Disability
Long-term Disability
Life & AD&D Insurance

The details of the premiums and benefits for all healthcare plans will be described in more detail during the Annual Open Enrollment process and in this guide.

I encourage you to take a moment to reflect on what is most important to you and your family. There is no better time than now to prioritize being proactive about our health and well-being. Over the course of the next year, we will provide you with information and resources to help you become a wiser healthcare consumer. I hope you will take advantage of it and spread the news to those around you.

Thank you for your contribution to Acme Brick. It is my sincere wish that you will have a happy, healthy year in 2026.

Ed Watson

## How to Enroll

If you are a newly hired associate, you have 31 days from your first day of employment to complete and submit your benefits enrollment form. Your benefits will be effective on the first of the month after 60 days of employment. For example, an associate who is hired on July 15th, their benefits will begin on October 1st.

### Before You Enroll

- ☑ Carefully review the benefits listed in this guide and determine coverage that is best for you and your family.
- ☑ Ensure dependents meet the eligibility requirements. If enrolling dependents for the first time, you must submit proof of eligibility (i.e., birth certificate, marriage certificate, etc.) to HR@brick.com.
- ☑ Understand the cost of the plans you selected.
- ☑ Estimate your family's out-of-pocket health care costs if you want to contribute to a Health Care Flexible Spending Account (FSA).
- ☑ Determine your family's child or adult care costs if you want to contribute to a Dependent Care FSA

Check with Human Resources at HR@brick.com if you have questions.

### New Hire Paper Enrollment

- ☑ Complete the paper enrollment form.
- ☑ Be sure to designate your beneficiary(s) for Life and AD&D insurance.
- ☑ Submit your completed form to HR@brick.com or your location administrator within 31 days from your date of hire.

### Annual Open Enrollment

- ☑ If you have an @brick.com email address, you must login to Employee Self Service (ESS) from the Acme Connect homepage.
- ☑ If you do not have an @brick.com email address, complete a paper enrollment form and return to HR@brick.com **from November 1st thru November 15th, 2025.**
- ☑ Be sure to designate or update your beneficiary(s) for Life and AD&D insurance.

## Eligibility and Waiting Periods

All benefit eligible associates who work at least 30 hours per week are eligible for the Acme Brick benefits offerings. For newly hired associates, most of your benefits are effective the first day of the month following sixty days of active employment. You may also enroll your eligible dependents for coverage. Eligible dependents include:

- Your legally married spouse or qualified domestic partner (of the same/opposite sex)
- Children under the age of 26, regardless of marital status, student status or dependency
- Children 26 or older who are fully dependent on you for support due to a mental or physical disability (and are indicated a such on your federal tax return)
- Dependent verification will be required at the time of enrollment

For details on eligibility and when your benefits begin and end, refer to your summary plan documents or contact HR@brick.com.

| Benefits Eligibility: Effective Dates and Termination Dates | | | |
|---|---|---|---|
| **Benefit Plan** | **Effective Date** | **Termination Date** | **Continuation After Termination** |
| **Medical/ Pharmacy** | first of the month following 60 days of employment | last day of active employment | eligible for COBRA continuation |
| **Teladoc/Livongo** | first of the month following 60 days of employment | last day of active employment | eligible for COBRA continuation |
| **Accident** | first of the month following 60 days of employment | last day of active employment | portability to an individual policy is available |
| **Critical Illness** | first of the month following 60 days of employment | last day of active employment | portability to an individual policy is available |
| **Dental** | first of the month following 60 days of employment | last day of active employment | eligible for COBRA continuation |
| **Vision** | first of the month following 60 days of employment | last day of active employment | eligible for COBRA continuation |
| **Flexible Spending Account (FSA)** | first of the month following 60 days of employment | last day of active employment | eligible for COBRA continuation |
| **Basic Life/AD&D** | first of the month following 60 days of employment | last day of active employment | may be converted to an individual policy (limitations apply) |
| **Voluntary Life/AD&D** | first of the month following 60 days of employment | last day of active employment | may be converted to an individual policy (limitations apply) |
| **Short-Term Disability** | first of the month following 60 days of employment | last day of active employment | no option to continue coverage |
| **Long-Term Disability** | first of the month following 60 days of employment | last day of active employment | portability to an individual policy is available (limitations apply) |

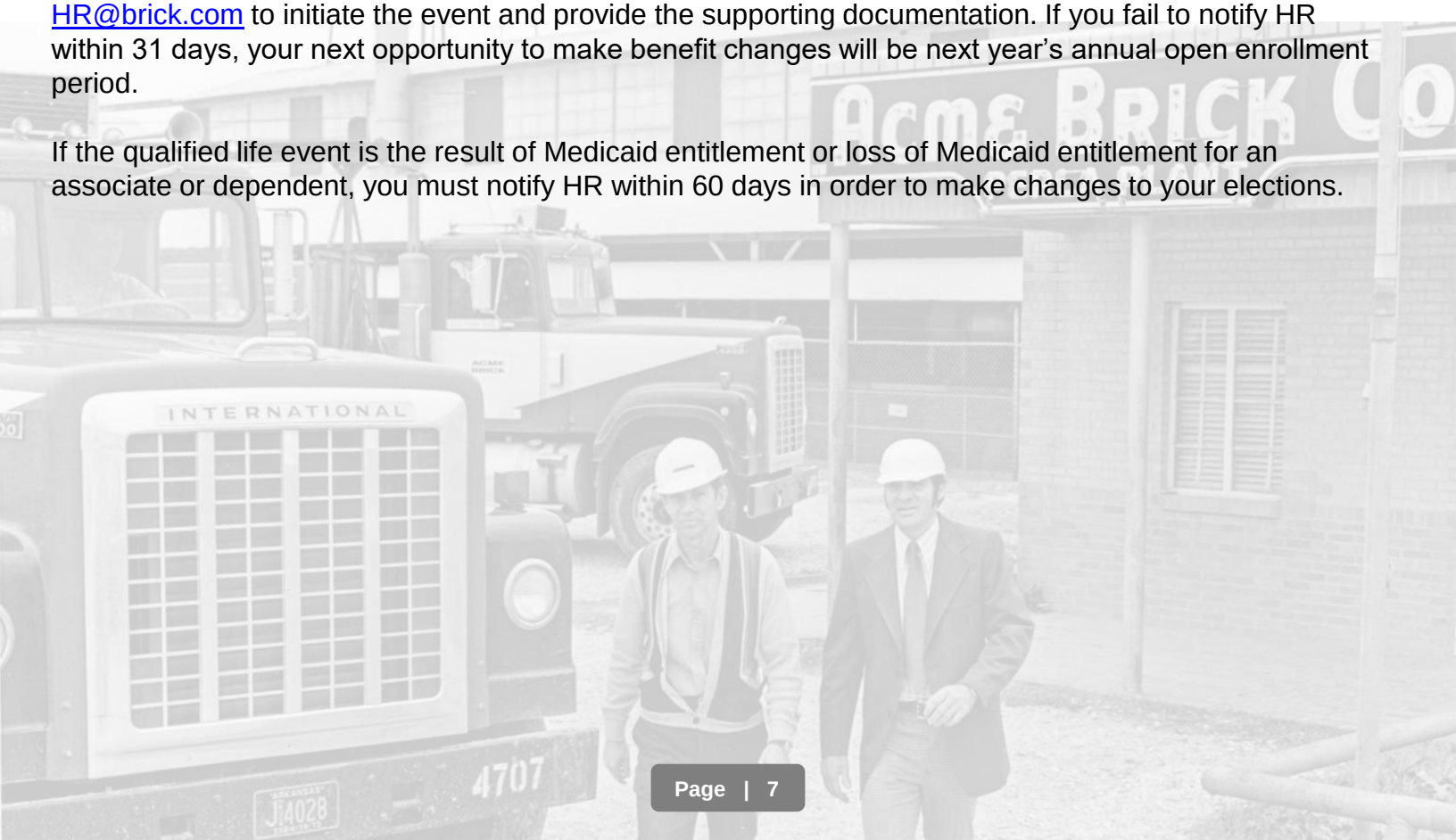
## When and How to Make Changes After Open Enrollment

During the year, you cannot make changes to your benefit elections unless you experience a Qualifying Life Event (QLE), such as marriage, divorce, the birth or adoption of a child. If you experience a QLE (examples provided below), contact Human Resources at HR@brick.com within 31 days of the event or you will have to wait until next year's open enrollment period to make changes.

| Qualifying Life Event (QLE) | Documentation Required |
|---|---|
| **Marriage** | Copy of marriage certificate |
| **Divorce or legal separation** | Copy of divorce decree |
| **Death of an eligible dependent** | Copy of death certificate |
| **Birth of a newborn or adoption** | Copy of birth certificate or copy of legal adoption papers |
| **Stepchild** | Copy of birth certificate plus a copy of the marriage certificate between the associate and spouse |
| **Gain or Loss Eligibility for Other Group Coverage** | Documentation from plan or issuer regarding change in eligibility (must include effective date) |
| **Associate, spouse or dependent Medicare/Medicaid entitlement, or loss of entitlement for Medicare/Medicaid** | Government verification that coverage was gained or lost (must include the effective date) |

You have only 31 days from the date of the event to make changes to your benefit elections. Contact HR@brick.com to initiate the event and provide the supporting documentation. If you fail to notify HR within 31 days, your next opportunity to make benefit changes will be next year's annual open enrollment period.

If the qualified life event is the result of Medicaid entitlement or loss of Medicaid entitlement for an associate or dependent, you must notify HR within 60 days in order to make changes to your elections.



## Cost of Coverage

Acme Brick pays the majority of the cost to provide benefits to you. You can see your applicable associate costs further in this guide.

**Select Medical Rates**

Annual open enrollment: To qualify for the reduced Select medical rates, associates and spouses enrolled in medical must be tobacco/nicotine-free. Only the associate must complete an annual physical. Please submit a completed Wellness Incentive Affidavit to HR@brick.com by December 1, 2025.

– If you do not have access to Acme Connect, you can get a copy of the affidavit from your local administrator.

For new hires: To qualify for the reduced Select medical rates, please submit a completed Wellness Incentive Affidavit within 31 days of your benefits effective date.

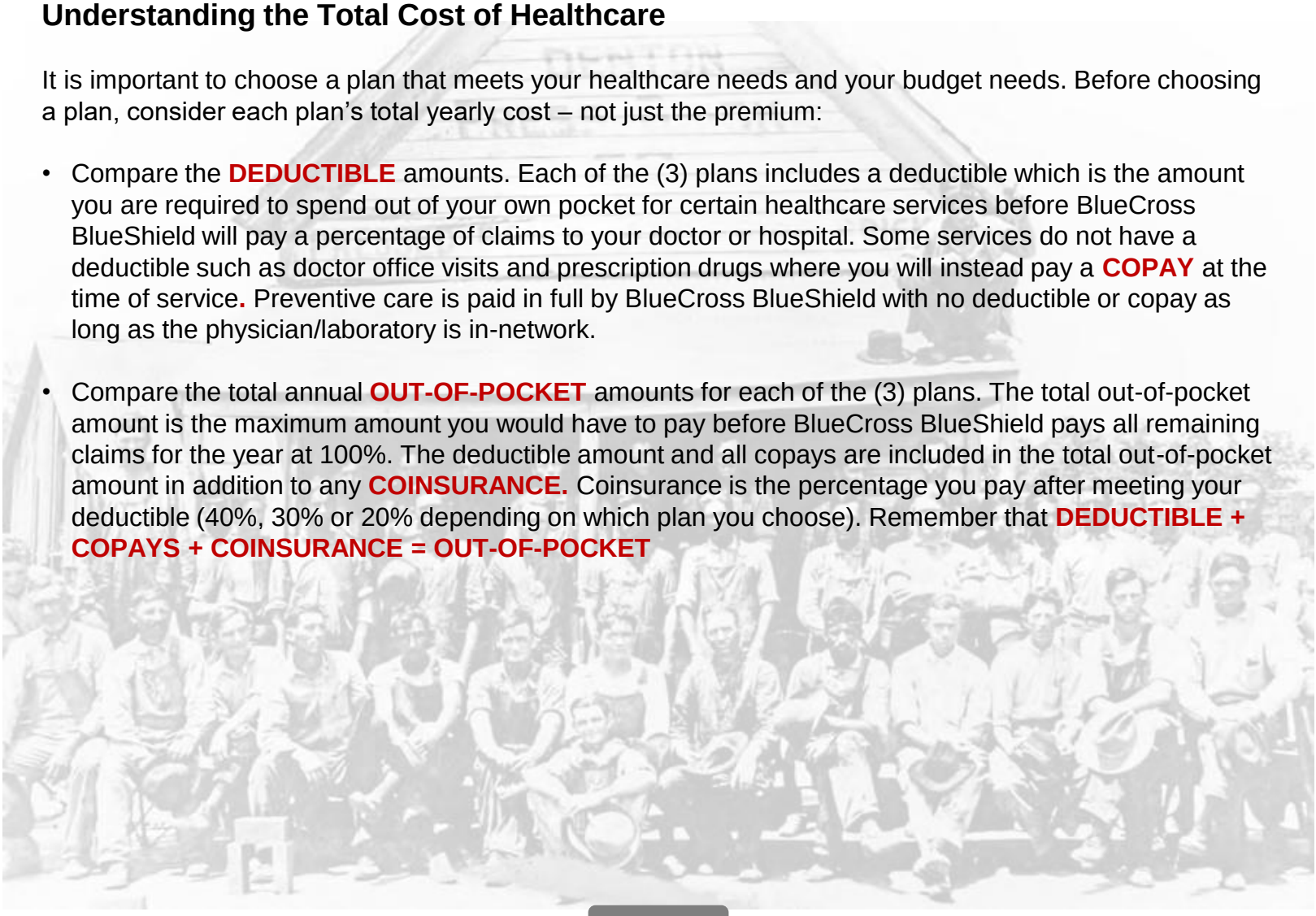
Tobacco/nicotine users who do not complete the smoking cessation program will be subject to the Standard medical plan rates. More information about tobacco/nicotine cessation programs available through BlueCross BlueShield of Texas can be found on page 14.

## Understanding the Total Cost of Healthcare

It is important to choose a plan that meets your healthcare needs and your budget needs. Before choosing a plan, consider each plan's total yearly cost – not just the premium:

- Compare the **DEDUCTIBLE** amounts. Each of the (3) plans includes a deductible which is the amount you are required to spend out of your own pocket for certain healthcare services before BlueCross BlueShield will pay a percentage of claims to your doctor or hospital. Some services do not have a deductible such as doctor office visits and prescription drugs where you will instead pay a **COPAY** at the time of service**.** Preventive care is paid in full by BlueCross BlueShield with no deductible or copay as long as the physician/laboratory is in-network.

- Compare the total annual **OUT-OF-POCKET** amounts for each of the (3) plans. The total out-of-pocket amount is the maximum amount you would have to pay before BlueCross BlueShield pays all remaining claims for the year at 100%. The deductible amount and all copays are included in the total out-of-pocket amount in addition to any **COINSURANCE.** Coinsurance is the percentage you pay after meeting your deductible (40%, 30% or 20% depending on which plan you choose). Remember that **DEDUCTIBLE + COPAYS + COINSURANCE = OUT-OF-POCKET**



## Medical Benefits
**Administered by BlueCross BlueShield Texas**

When it comes to medical coverage, Acme Brick provides you with choices. There are three medical plans to choose from, along with voluntary benefits such as Accident and Critical Illness to enhance your coverage.

- **Bronze Plan:**
  - highest deductibles and 40% coinsurance
  - highest out-of-pocket maximums
  - lowest cost per paycheck
- **Silver Plan**
  - lower deductibles and 30% coinsurance
  - lower out-of-pocket maximums
- **Gold Plan**
  - lowest deductibles and 20% coinsurance
  - lowest out-of-pocket maximums
  - highest cost per paycheck

These plans are administered by BlueCross BlueShield of Texas and cover medical services for you and your benefit eligible dependents to stay well and manage your health.

Each of these plans provides you with comprehensive benefits and includes copays when going to your primary care physician, a specialist or even urgent care.

No matter which plan you choose, you will have access to:
- A broad network of doctors, specialists and hospitals
- Preventive care services are covered in full with no deductible or out-of-pocket if you use a network provider.

**Prescription Drugs**
When you enroll in an Acme Brick medical plan, you automatically receive prescription drug coverage administered by Express Scripts. The same prescription drug benefits apply regardless of which medical plan you choose. The cost of your prescription drugs will depend on whether the drug is generic, preferred brand name, non-preferred brand name, or specialty drug and whether you purchase your prescription at an in-network pharmacy or through the Express Scripts Home Delivery program.

## Know Your Healthcare Lingo:

- **Coinsurance:** The percentage you owe after your deductible. For example, if your plan pays 80%, you are responsible for paying the remaining 20%.
- **Copay:** The fixed amount you pay to your provider for a covered service such as an office visit or prescription drug.
- **Annual Deductible:** The amount you pay for a health service before your medical plan starts paying.
- **In-Network Provider:** A doctor or hospital that accepts your plan allowance and cost-sharing as payment in full. Search for **Blue Choice** PPO providers online at bcbstx.com/find-care.
- **Annual Out-of-Pocket Maximum**: The most you will pay for covered medical services in any plan year. If you hit this amount, your medical plan pays 100% of covered services after that.
- **Preferred Drug List (PDL):** A list of prescription drugs covered by your prescription drug plan. Often referred to as the Prescription Drug Formulary.
- **Preventive Care**: Routine healthcare that includes screenings, check-ups and patient counseling to prevent illnesses and disease or other health problems.
- **Prior Authorization:** Approval from BlueCross BlueShield of Texas *may* be required for certain medical services before they are covered by your medical plan. Prior authorization *may* also be required from Express-Scripts for certain prescription drugs before they are covered.

## Comparison of Medical Plan Options

This chart compares your options for in-network services. Before you enroll, consider the per pay period cost and the cost of services and prescription drugs you expect to spend during the year. Evaluate how your out-of-pocket expenses may fluctuate and consider adding Voluntary Accident and Critical Illness benefits to help offset your out-of-pocket medical costs.

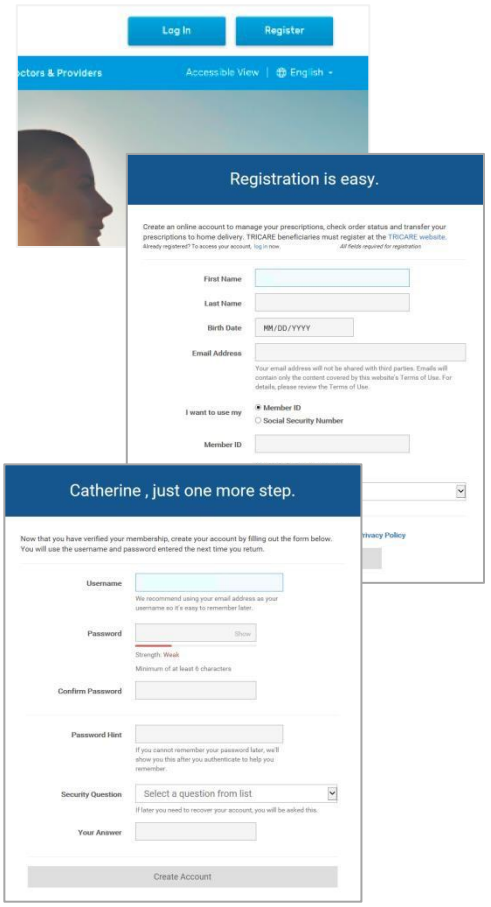
| | BRONZE PLAN | SILVER PLAN | GOLD PLAN |
|---|---|---|---|
| | IN-NETWORK YOU PAY | | |
| **Annual Deductible** (single/family) | $3,000/$9,000 | $2,000/$6,000 | $1,000/$3,000 |
| **Coinsurance** | You pay 40% | You pay 30% | You pay 20% |
| **Annual Out-Of-Pocket** (single/family) | $8,000/$16,000 | $7,000/$14,000 | $6,000/$12,000 |
| **Office visits – Primary Care** | $30 copay | | |
| **Office visits – Specialist** | $40 copay | | |
| **Office visits – Mental Health** (Psychologist/Psychiatrist) | $30 copay/$40 copay | | |
| **Preventive Care** (includes well childcare, immunizations, mammograms, pap smears, prostate exams, other preventive diagnostics, etc.) | covered in full with no deductible or out-of-pocket expense | | |
| **Teladoc – Virtual Visits** | $0 copay | | |
| **Urgent Care** | $30 copay | | |
| **Emergency Room – Facility** | $350 copay | | |
| **Emergency Room – Physician** | 40% after deductible | 30% after deductible | 20% after deductible |
| **Lab and X-Ray** | 40% after deductible | 30% after deductible | 20% after deductible |
| **Hospitalization - Outpatient** | 40% after deductible | 30% after deductible | 20% after deductible |
| **Hospitalization - Inpatient** | 40% after deductible | $250 copay + 30% after deductible | $250 copay + 20% after deductible |
| **Diagnostic Imaging** (MRI, CT, PET) | 40% after deductible | 30% after deductible | 20% after deductible |
| **Prescription Drugs** (30 day)<br>Tier 1 Generic<br>Tier 2 Preferred Brand<br>Tier 3 Non-Preferred Brand<br>Tier 4 Specialty<br>**Mail Order** (90 day) | <br>$10 copay<br>$50 copay<br>$70 copay<br>$125 copay<br>2 ½ x copay | | |

Avoid Surprise Bills!! Staying in-network means lower out-of-pocket costs for you, because providers and facilities cannot charge more than the BCBSTX allowable amounts for covered services. Ask your doctor to refer you to a specialist, hospital or surgical center that participates in the BCBSTX Blue Choice Network.

# Registering with Express Scripts

## Online Access to Savings and Convenience

Manage your medicines anywhere, any time with express-scripts.com and the Express Scripts™ mobile app.




Register now so you can experience:

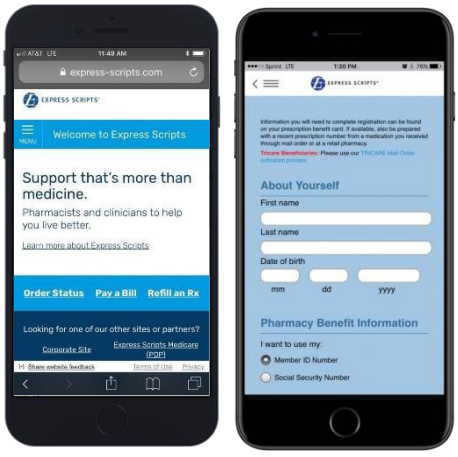
- **More savings.**
  Compare prices of medicines at multiple pharmacies. Get free standard shipping[1] from the Express Scripts Pharmacy℠.

- **More convenience.**
  Get up to 90-day supplies of your long-term medicine sent to your home. Order refills, check order status, and track shipments. Print forms and ID cards, if needed.

- **More confidence**.
  Talk with a pharmacist from the privacy of your home any time, from anywhere. Find the latest information on your medicine, including possible side effects and interactions.

- **More flexibility.**
  Download the Express Scripts mobile app to manage your medicines, find nearby pharmacies and get directions, and use your virtual ID card while on the go.

### Get Started Today!




Registering is safe and simple. Your information is secure and confidential. Please have your member ID number or SSN available.

1. Go to express-scripts.com, select Register or download the Express Scripts mobile app for free from your mobile device's app store and select Register.
2. Complete the information requested, including personal information and member ID number or Social Security Number (SSN), create your username and password, along with security information in case you ever forget your password.
3. Click Register Now and you're registered.
4. To set preferences[2], select Communication Preferences from the menu under Account, scroll to Communication and Viewing Preferences. Click Edit Preferences. Preferences can only be selected via the member website.

Members who have touch ID authentication on their mobile devices can enable it to log in to their Express Scripts account on the mobile app, if desired.

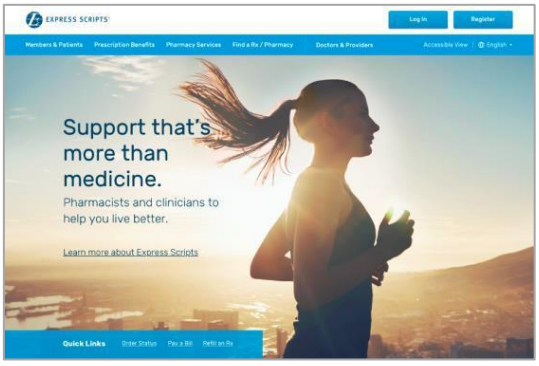
[1]Standard shipping costs are included as part of your prescription plan benefit.
[2]Preferences include the option to share your prescription information with other adult members of your household (aged 18+) covered under your prescription drug plan. All covered adults (aged 18+) in the household need to register separately. When you grant permission to share your prescription information with other registered household members, they can view your information, place orders on your behalf and more. The Express Scripts mobile app is available for iPhone®, iPad®, and Android™ mobile devices.

# Getting Started with Home Delivery
## from the Express Scripts Pharmacy℠

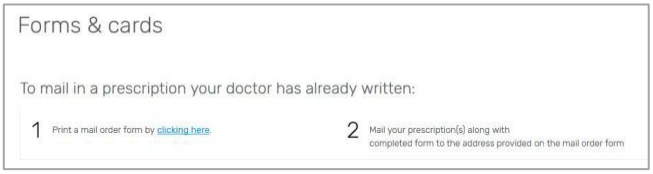
### Online Access to Savings and Convenience

Whether you are viewing the member website or using the Express Scripts™ mobile app[1], you can easily manage your home delivery prescriptions:

- Check order status
- Refill and renew prescriptions
- Check prices and coverage
- Find convenient pharmacies
- View your Rx claims and balances
- Pay your balance using a variety of payment options
- View our therapeutic resource centers for information
- And much more



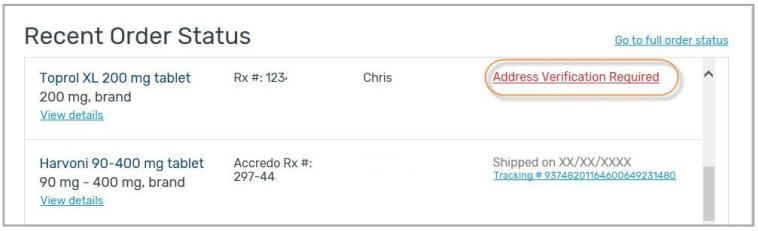

**To access the member website …**
Log in to **express-scripts.com** (Register if it is your first visit. Just have your member ID or SSN handy).

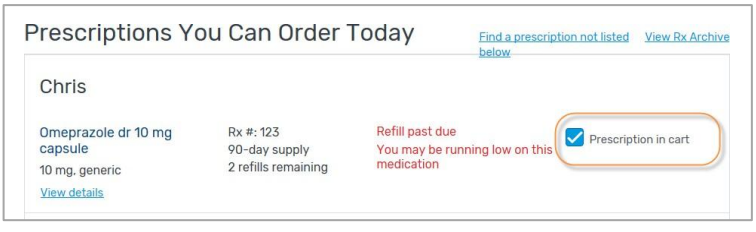



**If you have a NEW prescription …**
***Get Started*** by contacting your doctor to request a 90-day prescription that he or she can ePrescribe directly to Express Scripts,
***Or*** print a form by selecting "Forms" or "Forms & Cards" from the menu under "Benefits," print a mail order form and follow the mailing instructions,
***Or*** call us and we'll contact your doctor for you.
***Please allow 10 to 14 days for your first prescription order to be shipped.***

**If you already have a prescription …**
***Check Order Status*** online or using our app to view details and track shipping.

***Transfer Retail Prescriptions to Home Delivery.*** Just click "Add to Cart" for eligible prescriptions and check out. We'll contact your provider on your behalf and take care of the rest. Check ***Order Status*** to track your order.




***Refill and Renew Prescriptions*** for yourself and your family while online or using our app. Just click "Add to Cart" for eligible prescriptions and check out. We'll contact your provider on your behalf, if renewals are included, and take care of the rest.

[1] You can search for "Express Scripts" in your app store and download it for free. Then register, if first visit, or log in.

# Additional BlueCross BlueShield Texas Resources

## How to Find a PPO Provider

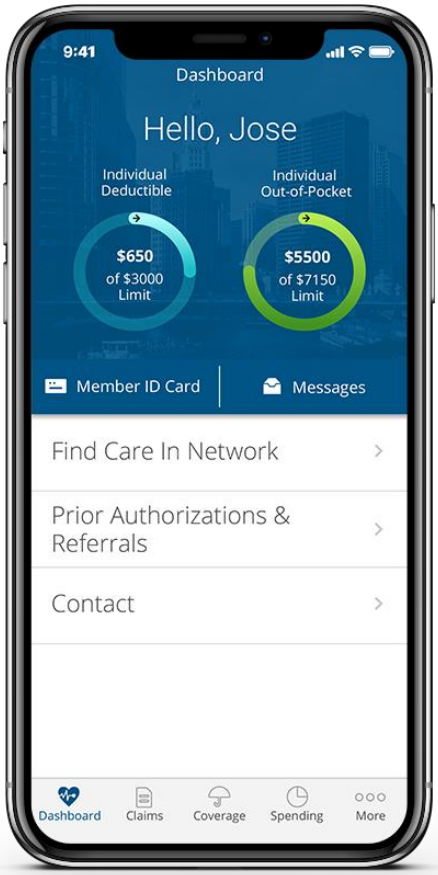
From your computer or mobile device, log on to **bcbstx.com®** and click on **Provider Finder.**

Call the Customer Service number on your ID card **800-521-2227.**

Speak with your provider's office.

## BCBSTX App for Mobile Devices

- Find an in-network doctor, hospital or urgent care facility, or search for Spanish-speaking doctors.
- Access your claims, coverage and deductible information.
- Access temporary digital member ID card.
- Secure login with Face ID (iOS only) and Fingerprint ID.
- **Let us know your communication preferences.**




Download on the App Store

Download for Apple

GET IT ON Google Play

Download for Android

Texas

## Tobacco/Nicotine Cessation Resources with BlueCross BlueShield of Texas

### Support is Available to Help You Quit

We want Associates to be engaged in their jobs and communities, and to achieve their highest level of well-being by removing nicotine from their lives. Our nicotine cessation program, provided through BlueCross BlueShield of Texas, is designed to:

- Provide healthy lifestyle education, resources and support .
- Help you lead a healthier life.
- Manage health care costs for the organization.
- Help you save on medical claims.

To qualify for Select rates you must be tobacco/nicotine free and complete an annual physical and submit your completed wellness incentive affidavit before December 1st.

Nicotine users who do not complete the cessation program will receive the Standard medical plan rates. Contact HR@brick.com with any questions.

#### Take Advantage of Tools and Support Available From Your Health Plan

Use of counseling or medicine — or using them together — can be part of an effective plan to quit tobacco/nicotine use, which is also referred to as tobacco/nicotine cessation.

Tobacco/nicotine cessation services are among the many preventive benefits available through your health plan as long as you visit a doctor in your health plan's provider network. There are no out-of-pocket costs like copays or coinsurance, even if you haven't met your deductible. Talk to your doctor about taking the next steps.

#### Counseling Covered

Tobacco/nicotine use cessation counseling sessions (including telephone, group, and individual counseling) led by qualified doctors are available at no cost share for members of non-grandfathered plans who use tobacco/nicotine products. Please refer to your benefits materials for information on what benefits are covered at no cost to you.*

#### Medications Covered

Your health plan also covers two 90-day treatments for tobacco/nicotine use cessation medicine per benefit period. This coverage includes a variety of FDA-approved tobacco/nicotine use cessation drugs (including both prescription and over-the-counter) when prescribed by your doctor.

#### Prescription Drugs Covered:

- Buproban (bupropion SR 150 mg tablets)
- Chantix
- Nicotrol Inhaler
- Nicotrol NS
- Zyban (bupropion SR 150 mg tablets)

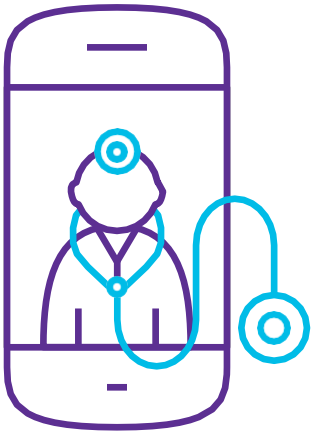
#### Over-the-Counter Drugs Covered:

- Commit
- Nicotine Transdermal Kits
- Nicoderm CQ and generics
- Nicorette gum and generics
- Nicorette lozenges and generics

**For More Information:**

To learn more about tobacco/nicotine cessation coverage under your BCBSTX health plan, call the Customer Service number located on the back of your member ID card.

## Virtual Visits
**Provided by Teladoc Health**



**Teladoc is available to all members enrolled in one of the Acme Brick medical plans administered by BCBSTX.**

***$0 copay***

Your access to Teladoc lets you **talk with a doctor anytime**, anywhere, through phone or through the convenience of online video consults, 24 hours, 7 days a week.

1. Talk to a doctor anytime, anywhere you happen to be
2. Receive quality care via phone, video or mobile app
3. Prompt treatment, talk to a doctor in minutes
4. A network of doctors that can treat every member of the family
5. Prescriptions sent to pharmacy of choice if medically necessary
6. Teladoc is less expensive than the ER or urgent care

### GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink eye
- Respiratory infection
- Sinus problems
- Skin problems
- And more!

With your consent, Teladoc is happy to provide information about your Teladoc visit to your primary care physician.

**Talk to a Doctor Anytime!**

**DOWNLOAD THE APP -** Available in the App Store and on Google Play

Teladoc.com

1-800-TELADOC (835-2362)

Available on the iPhone App Store

ANDROID APP ON Google play

**Diabetes Management Program**
**Administered by Livongo/Teladoc Health**

Livongo by Teladoc Health

# Turn the Tables on Diabetes

**The Diabetes Management Program** can help you maintain your blood sugar levels for **better overall health**.

Normal blood sugar is
**80-130** mg/dL[1]
before meals

After meals, it should still be less than
**180** mg/dL[1]

**Where do you fall?**

### The Highs and Lows of Blood Sugar

When you have diabetes, it's important to track your blood sugar regularly. By monitoring, you can:

- See if your lifestyle choices are working
- Get immediate feedback
- Collect data your Livongo team can use to help you

### Manage Your Overall Health

- Take your medicine
- Eat a balanced diet
- Stay active
- Get enough sleep
- Check your blood sugar

**The Diabetes Management Program from Livongo** provides the support and tools you need to help you reach your health goals. This program can help you get your blood sugar levels under control, which is pretty sweet.

> "I've got all these great tools. You have the ability to download and have access to all your records. It's really good. I wish I would have started using it a lot longer ago." John S.

**Get Started with Livongo Today**

Visit Join.Livongo.com/ACME/Register or call 800-945-4355 or download the app Use your registration code: ACME

[1]https://medlineplus.gov/bloodglucose.html

Livongo program communications are available in Spanish. When you sign up, you will be able to set your preferred language for meter and program communications. To enroll in Spanish, call 800-945-4355 or visit Hola.Livongo.com/ACME. The testimonials, statements and opinions presented are applicable to the individuals depicted. Each member's exact results and experience will be unique and individual to each member. The testimonials are voluntarily provided and are not paid. Program includes trends and support on your secure Livongo account and mobile app but does not include a phone or tablet. You must have an iPhone or Android smartphone and install the Livongo app to participate in the Livongo program. 

# Muscle and Joint Pain Prevention Resources for BlueCross BlueShield of Texas Members Powered by Hinge Health

ACME BRICK | Hinge Health

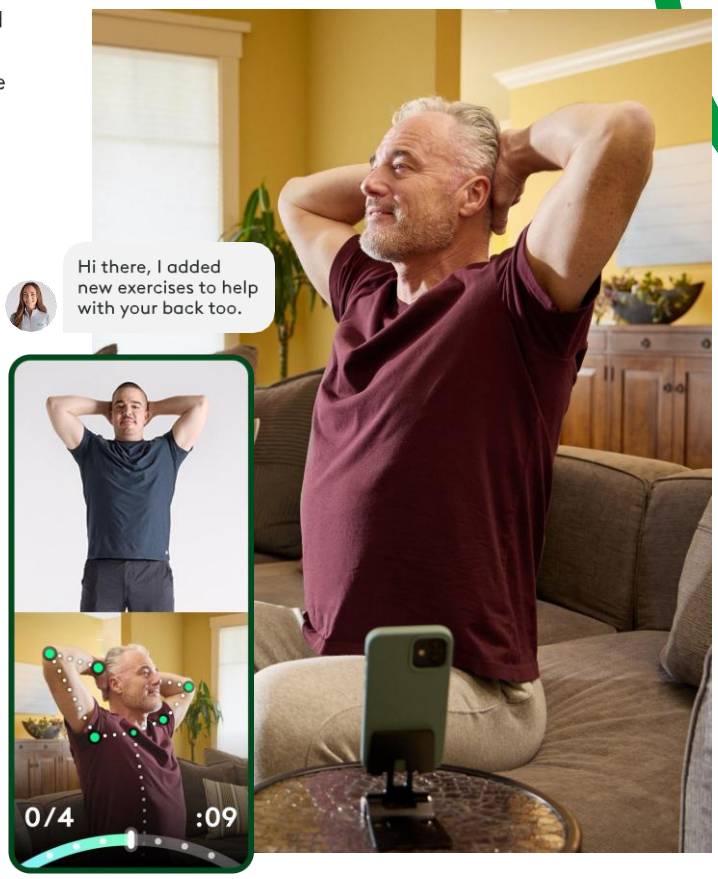
IT'S TIME TO START THINKING ABOUT YOUR ANNUAL BENEFITS!

## Tackle joint and muscle pain where you need it most

With Hinge Health, get access to virtual physical therapy and more to help you recover from injuries, build strength, relieve pelvic pain and discomfort and more. Whether your aches are short-term or chronic, we'll help you get moving again.

### Specialized care, personalized for you

- **1-on-1 support**
  Work with a dedicated physical therapist and health coach to treat multiple body parts.
- **A care plan on your terms**
  Get tailored exercises and video visits with your physical therapist that fit seamlessly into your busy life.
- **Technology that works for you**
  Improve your form and build your confidence during exercises with real-time audio & visual guidance from our app.
- **All costs covered**
  You earned Hinge Health benefits through Acme Brick Company.




Sign up today.
Scan the QR code or visit:
hinge.health/acmebrick-25

Please use the default camera on your device to scan the QR code, not a third-party application. If you are directed to a site other than the URL listed above, do not proceed.

**NEW MEMBERS ONLY**
**Start your program, and get a massage gun on us!***

# Muscle & Joint Pain

## Airrosti Can Help!

ACME BRICK

## Head-to-Toe Care

- BACK PAIN
- KNEE PAIN
- WRIST PAIN
- ARM PAIN
- FOOT PAIN
- PLUS MORE

**Reduce Pain in 3-4 Visits***

**Based on patient-reported outcomes*

## Two Effective Options Available

### In-Person Care

Care starts with a thorough evaluation to find the cause of your pain. An accurate diagnosis is the key to creating a custom treatment plan that will be successful for you. Effective hands-on manual therapy and prescribed exercises will help you get out of pain and stay out of pain.

### Virtual Care


With Airrosti Remote Recovery, you will receive the same quality care but with convenient remote access. You will get a detailed visual evaluation, a comprehensive diagnosis, and a custom treatment plan - all delivered through a user friendly app. The Remote Recovery Kit will help you recover faster. Using the rehab tools in the kit, you will be guided through manual therapy movements along with prescribed exercises to get you back to a pain free life.

Scan to schedule today
or call 800-404-6050
For more information, visit Airrosti.com

AIRROSTI®
WE FIX PAIN FAST

## Medical Plan Cost
**(53 weekly payroll deductions)**

| BRONZE PLAN | | |
|---|---|---|
| | **Select Rates** | **Standard Rates** |
| **Associate Only** | $23.88 | $41.73 |
| **Associate + Spouse** | $86.43 | $109.36 |
| **Associate + Child(ren)** | $48.64 | $68.50 |
| **Associate + Family** | $109.40 | $134.20 |

| SILVER PLAN | | |
|---|---|---|
| | **Select Rates** | **Standard Rates** |
| **Associate Only** | $38.59 | $58.87 |
| **Associate + Spouse** | $123.34 | $151.16 |
| **Associate + Child(ren)** | $72.75 | $96.07 |
| **Associate + Family** | $158.62 | $189.59 |

| GOLD PLAN | | |
|---|---|---|
| | **Select Rates** | **Standard Rates** |
| **Associate Only** | $52.75 | $75.48 |
| **Associate + Spouse** | $167.61 | $198.36 |
| **Associate + Child(ren)** | $94.72 | $121.36 |
| **Associate + Family** | $209.83 | $239.49 |

## Flexible Spending Accounts
**Administered by Wex Health**

Flexible Spending Accounts (FSAs) allow you to pay for eligible healthcare (including dental and vision) and dependent childcare expenses using tax-free dollars.

- **Healthcare FSA** – used to pay for out-of-pocket expenses associated with medical, dental and vision plans such as copayments, coinsurance, deductibles, prescription drug expenses, lab exams and tests, contacts lenses and eyeglasses for you and your eligible dependents.
- **Dependent Care FSA –** used to pay for dependent care expenses such as daycare, before and after school programs, day camps, preschool/nursery school, etc. expenses that are necessary for you or your spouse to work or attend school full-time.

**IMPORTANT**: The IRS has a "use it or lose it" rule. If you do not spend down all of the money you elected to put in your FSA by the annual deadline, any unused dollars in your account fill be forfeited.

| How the Healthcare FSA Works | How the Dependent Care FSA Works |
|---|---|
| You may contribute up to **$3,400** per year as a pre-tax payroll contribution | You may contribute up to **$7,500** per year as a pre-tax payroll contribution, or **$3,750** if married filing separate tax returns |
| You receive a debit card to pay for eligible healthcare expenses, including dental and vision | You submit claims for reimbursement; no debit cards are provided; funds must be available in your account |
| Eligible expenses include copays, coinsurance, deductibles, eyeglasses, contact lenses and some over-the-counter medications if prescribed by your doctor | Can be used to pay for eligible dependent care expenses including daycare, after-school programs and elder care programs for your aging parents |
| Submit claims up to March 31st of 2027 for expenses incurred from January 1, 2026 thru March 15, 2027. | Submit claims up to March 31st of 2027 for expenses incurred January 1, 2026 thru December 31, 2026. |
| If you do not spend all of the funds that you elected to contribute by March 15, 2027, those unused dollars are forfeited per IRS rules. | If you do not spend all of the funds that you elected to contribute by December 31, 2026, those unused dollars are forfeited per IRS rules. |

| How you can save taxes with an FSA | |
|---|---|
| **Your annual gross earnings** | $50,000 |
| **Estimated 2026 total healthcare expenses** (deductibles, copays, co-insurance, dental expenses, vision expenses) | $5,000 |
| **Your 2026 FSA election** | $3,400 |
| **Potential federal income tax savings** | $396 |
| **Potential FICA tax savings** | $253 |
| **Potential Total Tax Savings** | **$649** |

**REMINDER:** Calendar year 2026 will have 53 pay periods. Keep that in mind when determining your FSA contribution amount.

## Dental
### Administered by Cigna

You have two dental coverage options through Cigna: DHMO plan and a traditional PPO plan. The DHMO plan is a copay plan and has lower associate contributions. You must choose a general dentist from the Cigna Dental Care Access network who can refer you to a specialist if needed. The traditional PPO plan allows you to receive services from any Cigna network dentist and enjoy negotiated network discounts.

| | DHMO Plan | PPO Plan | |
|---|---|---|---|
| | **In-Network Only you pay** | **In-Network you pay** | **Out-of-Network you pay** |
| **Calendar year deductible**<br>Individual/Family | None | $50/$150 | |
| **Calendar Year Maximum Benefit**<br>Class 1, 2, 3 | Unlimited | $2,000 | |
| **Class 1: Diagnostic & Preventive**<br>Oral evaluation, routine cleanings, x-rays,<br>fluouride, sealants, space maintainers, emergency care to relieve pain | exam, cleanings, x-rays: $0; sealants: $8 - $12 per tooth; space maintainers: $110-$170 | 0% | 0% |
| **Class 2: Basic Restorative**<br>Fillings, endodontics, periodontics, oral surgery, anesthesia, repairs to crowns, dentures and bridges, surgical extractions of impacted teeth | fillings: $72; simple extractions: $12-$53; oral surgery: $110-$400; periodontics: $42-$430; endodontics: $14-$350 | 20%<br>after deductible | 20%<br>after deductible |
| **Class 3: Major Restorative**<br>Inlays/onlays, prosthesis over implant, crowns, dentures, bridges | crowns: $410-$790; inlays/onlays: $390-$460; dentures: $525-$680; bridges: $1,200-$2,400 | 50%<br>after deductible | 50%<br>after deductible |
| **Class 4: Orthodontia** NEW<br>For children to age 19<br>Lifetime Benefits Maximum: $2,000 | $2,040 - $2,376<br>adults and children | 50% | 50% |
| **Waiting Periods**<br>Class 3 Major Restorative<br>Class 4 Orthodontia | None | None | |
| **Maximum Reimbursement Level** | Copays based on contracted fee schedule | Based on contracted fees; member not responsible for discounted amounts | Based on maximum reimbursable charge (MRC); member responsible for amounts exceeding the MRC. |

## Dental (continued)

Maintaining proper oral care can really have an impact on your overall health. Our plan through Cigna covers two cleaning per year at no cost.

It's not just Plaque and Bad Breath. Did you know that poor oral health can contribute to the following?

1. Increased risk of Cardiovascular Disease
2. Increased Risk of Erectile Dysfunction
3. Risk for certain Cancers
4. High Blood Sugar (Diabetes) – People with existing Diabetes already have an increased risk for gum disease
5. Increased risk for developing Kidney Disease
6. Increased risk for Dementia
7. Risk for developing Rheumatoid Arthritis
8. Higher rate of Respiratory Infections
9. Issues with Fertility
10. Pregnancy Complications

People who get regular preventive care are 22% less likely to need care at an emergency room or urgent care center.

You may enroll yourself and your eligible dependents or you may waive dental coverage. You do not have to be enrolled in medical coverage to elect a dental plan. Acme Brick offers dental coverage through Cigna. For information on finding a dental provider using the Cigna Access Plus or Advantage network, visit www.cigna.com and click on Find a Doctor, Dentist or Facility.

Digital ID cards are available online at www.myCigna.com or through the mobile app. Paper copies will not be printed, but you can email your ID card directly to your dentist or save them to your Apple Wallet.

**Before You Enroll Consider this:**

1. Most in-network preventive cleanings and exams are covered at 100%.
2. You may receive dental care in- or out-of-network. However, when you go out of network, the provider can charge more and the plan will only reimburse up to the reasonable and customary rates.

### DHMO Option

If you decide to enroll in the DHMO Option for the first time or add new dependents under this option, you need to select a primary care dentist. You can choose a different DHMO dentist for yourself and each covered dependent.

You should consult the participating provider directory prior to enrolling. The directory lists the dentists who are members of the network, any services performed by a non-network provider are not covered.

To search the online provider directory:

1. Go to www.cigna.com.
2. Click on "Find a Doctor" located at the top of the screen
3. Click on "Employer or School" when asked "How are you covered?
4. Enter your address and click your search type: doctor by type, doctor by name or health facilities
5. Select the type of dentist that you are looking for, then select to continue as guest and click the blue Continue button again
6. Under CIGNA DENTAL CARE DHMO select Cigna Dental Care Access

Still need help? Call 800-Cigna24 (800-244-6224)

## Vision

**Insured by Davis Vision, a Versant Health/MetLife company**

Healthy eyes and clear vision are an important part of your overall health and quality of life. You may enroll yourself and your eligible dependents or you may waive vision coverage. You do not have to be enrolled in medical coverage to elect a vision plan.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

Versant Health is dedicated to providing a breadth of choices through its industry-leading networks. Our network partners include Target Optical, Pearle Vision (select locations), and For Eyes retail locations. It is important to confirm participation through the member website at davisvision.com/locator or calling 800-999-5431.

| | In Network<br>You pay | Out-of-Network<br>Maximum Reimbursement |
|---|---|---|
| **Exam** | $10 copay | $45 |
| **Materials** | $25 copay | see below |
| **Covered Services – Lenses/Frames** | | |
| **Single lens** | $25 copay | $40 |
| **Bifocal** | $25 copay | $60 |
| **Trifocal** | $25 copay | $80 |
| **Lens Enhancements**<br>Tinting<br>Scratch-resistant<br>U/V coating<br>Anti-reflective coating<br>Polycarbonate lenses<br>Progressive lenses | <br>$0<br>$0 - $12<br>$30<br>$35 - $85<br>$0 - $30<br>$50 - $175 | applied to the allowance for the applicable corrective lens |
| **Frames** | $160 allowable +<br>20% discount off balance | $75 |
| **Covered Services – Contact Lenses In Lieu of Lenses/Frames** | | |
| **Contacts –<br>medically necessary** | $0 | $225 |
| **Contacts –<br>elective** | $160 allowable +<br>15% discount off balance | $100 |
| **Benefit Frequency** | | |
| **Exams** | once every 12 months | |
| **Lenses** | once every 12 months | |
| **Frames** | once every 12 months | |
| **Contacts (in lieu of lenses)** | once every 12 months | |

## Dental and Vision Cost
**(weekly payroll deductions)**

| Dental – DHMO Plan | |
|---|---|
| **Associate Only** | $1.49 |
| **Associate + Spouse** | $2.73 |
| **Associate + Child(ren)** | $3.13 |
| **Associate + Family** | $4.79 |

| Dental – PPO Plan | |
|---|---|
| **Associate Only** | $2.78 |
| **Associate + Spouse** | $4.97 |
| **Associate + Child(ren)** | $5.95 |
| **Associate + Family** | $8.34 |

| Vision Plan | |
|---|---|
| **Associate Only** | $1.25 |
| **Associate + Spouse** | $2.51 |
| **Associate + Child(ren)** | $2.63 |
| **Associate + Family** | $3.67 |

# Life Insurance
## Insured by Prudential

**Basic Life and Accidental Death and Dismemberment (AD&D):**
Acme Brick automatically provides all full-time associates with Basic Life/AD&D insurance in the amount of $20,000.

Accidental Death and Dismemberment (AD&D) provides additional benefits if you die or suffer a covered loss in an accident, such as losing a limb or your eyesight.

**Supplemental Life and Accidental Death & Dismemberment (AD&D)**
If you would like to purchase additional life insurance coverage, you can elect Voluntary Life and AD&D insurance for yourself, spouse and your dependent child(ren).

**Supplemental Life and AD&D – for You and Your Dependents**

| | Associate | Spouse | Child(ren) |
|---|---|---|---|
| **Benefit Amount** | Increments of $25,000 up to $300,000 | Increments of $5,000 up to $150,000 not to exceed 50% of the associate's elected amount | $10,000<br><br>($250 for children 14 days to 6 months of age) |
| **Guaranteed Issue (GI)** | $300,000 | $50,000 | $10,000 |
| **Age Reduction** | 35% at age 65<br>60% at age 70<br>75% at age 75<br>90% at age 80 | 35% when associate turns 65<br><br>Terminates when associate turns 70 or retires, whichever comes first | n/a |

**Special 2026 Annual Enrollment Opportunity**
For the 2026 Annual Open Enrollment only, associates may elect or increase their current Supplemental Life and AD&D coverage without completing Evidence of Insurability (EOI). This one-time opportunity applies only during the 2026 enrollment period. This special one-time opportunity also applies to spouse coverage up to the guarantee issue limit of $50,000.

# Supplemental Life and AD&D Cost
**(weekly payroll deductions)**

## EMPLOYEE COVERAGE OPTIONS

| Age | $25,000 | $50,000 | $75,000 | $100,000 | $125,000 | $150,000 | $175,000 | $200,000 | $225,000 | $250,000 | $275,000 | $300,000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **< 25** | $0.42 | $0.84 | $1.26 | $1.68 | $2.11 | $2.53 | $2.95 | $3.37 | $3.79 | $4.21 | $4.63 | $5.05 |
| **25 – 29** | $0.48 | $0.96 | $1.44 | $1.92 | $2.39 | $2.87 | $3.35 | $3.83 | $4.31 | $4.79 | $5.27 | $5.75 |
| **30 – 34** | $0.59 | $1.19 | $1.78 | $2.38 | $2.97 | $3.57 | $4.16 | $4.75 | $5.35 | $5.94 | $6.54 | $7.13 |
| **35 – 39** | $0.71 | $1.42 | $2.13 | $2.84 | $3.55 | $4.26 | $4.97 | $5.68 | $6.39 | $7.10 | $7.81 | $8.52 |
| **40 – 44** | $0.88 | $1.77 | $2.65 | $3.53 | $4.41 | $5.30 | $6.18 | $7.06 | $7.94 | $8.83 | $9.71 | $10.59 |
| **45 – 49** | $1.23 | $2.46 | $3.69 | $4.92 | $6.14 | $7.37 | $8.60 | $9.83 | $11.06 | $12.29 | $13.52 | $14.75 |
| **50 – 54** | $1.81 | $3.61 | $5.42 | $7.22 | $9.03 | $10.83 | $12.64 | $14.45 | $16.25 | $18.06 | $19.86 | $21.67 |
| **55 – 59** | $3.31 | $6.61 | $9.92 | $13.22 | $16.53 | $19.83 | $23.14 | $26.45 | $29.75 | $33.06 | $36.36 | $39.67 |
| **60 – 64** | $4.92 | $9.84 | $14.76 | $19.68 | $24.61 | $29.53 | $34.45 | $39.37 | $44.29 | $49.21 | $54.13 | $59.05 |
| **65 – 69** | $8.90 | $17.80 | $26.71 | $35.61 | $44.51 | $53.41 | $62.31 | $71.22 | $80.12 | $89.02 | $97.92 | $106.82 |
| **70+** | $12.02 | $24.03 | $36.05 | $48.07 | $60.09 | $72.10 | $84.12 | $96.14 | $108.16 | $120.17 | $132.19 | $144.21 |

## SPOUSE COVERAGE OPTIONS

| Age | $5,000 | $10,000 | $15,000 | $20,000 | $25,000 | $30,000 | $35,000 | $40,000 | $45,000 | $50,000 | $55,000 | $60,000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **< 25** | $0.08 | $0.17 | $0.25 | $0.34 | $0.42 | $0.51 | $0.59 | $0.67 | $0.76 | $0.84 | $0.93 | $1.01 |
| **25 – 29** | $0.10 | $0.19 | $0.29 | $0.38 | $0.48 | $0.57 | $0.67 | $0.77 | $0.86 | $0.96 | $1.05 | $1.15 |
| **30 – 34** | $0.12 | $0.24 | $0.36 | $0.48 | $0.59 | $0.71 | $0.83 | $0.95 | $1.07 | $1.19 | $1.31 | $1.43 |
| **35 – 39** | $0.14 | $0.28 | $0.43 | $0.57 | $0.71 | $0.85 | $0.99 | $1.14 | $1.28 | $1.42 | $1.56 | $1.70 |
| **40 – 44** | $0.18 | $0.35 | $0.53 | $0.71 | $0.88 | $1.06 | $1.24 | $1.41 | $1.59 | $1.77 | $1.94 | $2.12 |
| **45 – 49** | $0.25 | $0.49 | $0.74 | $0.98 | $1.23 | $1.47 | $1.72 | $1.97 | $2.21 | $2.46 | $2.70 | $2.95 |
| **50 – 54** | $0.36 | $0.72 | $1.08 | $1.44 | $1.81 | $2.17 | $2.53 | $2.89 | $3.25 | $3.61 | $3.97 | $4.33 |
| **55 – 59** | $0.66 | $1.32 | $1.98 | $2.64 | $3.31 | $3.97 | $4.63 | $5.29 | $5.95 | $6.61 | $7.27 | $7.93 |
| **60 – 64** | $0.98 | $1.97 | $2.95 | $3.94 | $4.92 | $5.91 | $6.89 | $7.87 | $8.86 | $9.84 | $10.83 | $11.81 |
| **65 – 69** | $1.78 | $3.56 | $5.34 | $7.12 | $8.90 | $10.68 | $12.46 | $14.24 | $16.02 | $17.80 | $19.58 | $21.36 |

*Spouse rate is based on employee age. Spouse coverage terminates at age 70.*

## SPOUSE COVERAGE OPTIONS (continued)

| Age | $65,000 | $70,000 | $75,000 | $80,000 | $85,000 | $90,000 | $95,000 | $100,000 | $105,000 | $110,000 | $115,000 | $120,000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **< 25** | $1.10 | $1.18 | $1.26 | $1.35 | $1.43 | $1.52 | $1.60 | $1.68 | $1.77 | $1.85 | $1.94 | $2.02 |
| **25 – 29** | $1.25 | $1.34 | $1.44 | $1.53 | $1.63 | $1.72 | $1.82 | $1.92 | $2.01 | $2.11 | $2.20 | $2.30 |
| **30 – 34** | $1.55 | $1.66 | $1.78 | $1.90 | $2.02 | $2.14 | $2.26 | $2.38 | $2.50 | $2.61 | $2.73 | $2.85 |
| **35 – 39** | $1.85 | $1.99 | $2.13 | $2.27 | $2.41 | $2.55 | $2.70 | $2.84 | $2.98 | $3.12 | $3.26 | $3.41 |
| **40 – 44** | $2.30 | $2.47 | $2.65 | $2.82 | $3.00 | $3.18 | $3.35 | $3.53 | $3.71 | $3.88 | $4.06 | $4.24 |
| **45 – 49** | $3.20 | $3.44 | $3.69 | $3.93 | $4.18 | $4.42 | $4.67 | $4.92 | $5.16 | $5.41 | $5.65 | $5.90 |
| **50 – 54** | $4.70 | $5.06 | $5.42 | $5.78 | $6.14 | $6.50 | $6.86 | $7.22 | $7.58 | $7.95 | $8.31 | $8.67 |
| **55 – 59** | $8.60 | $9.26 | $9.92 | $10.58 | $11.24 | $11.90 | $12.56 | $13.22 | $13.88 | $14.55 | $15.21 | $15.87 |
| **60 – 64** | $12.80 | $13.78 | $14.76 | $15.75 | $16.73 | $17.72 | $18.70 | $19.68 | $20.67 | $21.65 | $22.64 | $23.62 |
| **65 – 69** | $23.15 | $24.93 | $26.71 | $28.49 | $30.27 | $32.05 | $33.83 | $35.61 | $37.39 | $39.17 | $40.95 | $42.73 |

*Spouse rate is based on employee age. Spouse coverage terminates at age 70.*

# Supplemental Life and AD&D Cost (continued)
**(weekly payroll deductions)**

## SPOUSE COVERAGE OPTIONS (continued)

| Age | $125,000 | $130,000 | $135,000 | $140,000 | $145,000 | $150,000 |
|---|---|---|---|---|---|---|
| **< 25** | $2.11 | $2.19 | $2.27 | $2.36 | $2.44 | $2.53 |
| **25 – 29** | $2.39 | $2.49 | $2.59 | $2.68 | $2.78 | $2.87 |
| **30 – 34** | $2.97 | $3.09 | $3.21 | $3.33 | $3.45 | $3.57 |
| **35 – 39** | $3.55 | $3.69 | $3.83 | $3.97 | $4.12 | $4.26 |
| **40 – 44** | $4.41 | $4.59 | $4.77 | $4.94 | $5.12 | $5.30 |
| **45 – 49** | $6.14 | $6.39 | $6.64 | $6.88 | $7.13 | $7.37 |
| **50 – 54** | $9.03 | $9.39 | $9.75 | $10.11 | $10.47 | $10.83 |
| **55 – 59** | $16.53 | $17.19 | $17.85 | $18.51 | $19.17 | $19.83 |
| **60 – 64** | $24.61 | $25.59 | $26.57 | $27.56 | $28.54 | $29.53 |
| **65 – 69** | $44.51 | $46.29 | $48.07 | $49.85 | $51.63 | $53.41 |

*Spouse rate is based on employee age. Spouse coverage terminates at age 70.*

## CHILD COVERAGE

| | $10,000 |
|---|---|
| newborns through age 26 (if unmarried) | $.51 |

# Additional Voluntary Accidental Death and Dismemberment (AD&D)

| Additional Voluntary AD&D – for You and Your Dependents<br>*(in addition to the Supplemental AD&D on prior pages)* | | | | |
|---|---|---|---|---|
| | **OPTION 1**<br>**Associate Only** | **OPTION 2**<br>**Associate + Spouse** | **OPTION 3**<br>**Associate + Child** | **OPTION 4**<br>**Associate + Family** |
| **Benefit Amount** | increments of $50,000 up to $500,000; not to exceed 10× your base annual earnings | 50% of associate's elected amount | 15% of associate's elected amount to a maximum of $20,000 | **Spouse:**<br>40% of associate's elected amount<br><br>**Child(ren):**<br>10% of associate's elected amount to a maximum of $20,000 |

# Additional Voluntary Accidental Death and Dismemberment (AD&D)
**(weekly payroll deductions)**

**OPTION 1 – ASSOCIATE ONLY**

| Associate Benefit Amount | Weekly Payroll Deduction |
|---|---|
| $50,000 | $0.27 |
| $100,000 | $0.53 |
| $150,000 | $0.80 |
| $200,000 | $1.06 |
| $250,000 | $1.33 |
| $300,000 | $1.59 |
| $350,000 | $1.86 |
| $400,000 | $2.12 |
| $450,000 | $2.39 |
| $500,000 | $2.65 |

**OPTION 2 – ASSOCIATE + SPOUSE**

| Associate Benefit Amount | Spouse Benefit Amount | Weekly Payroll Deduction |
|---|---|---|
| $50,000 | $25,000 | $0.40 |
| $100,000 | $50,000 | $0.80 |
| $150,000 | $75,000 | $1.19 |
| $200,000 | $100,000 | $1.59 |
| $250,000 | $125,000 | $1.99 |
| $300,000 | $150,000 | $2.39 |
| $350,000 | $175,000 | $2.79 |
| $400,000 | $200,000 | $3.18 |
| $450,000 | $225,000 | $3.58 |
| $500,000 | $250,000 | $3.98 |

**OPTION 3 – ASSOCIATE + CHILD(REN)**

| Associate Benefit Amount | Child(ren) Benefit Amount | Weekly Payroll Deduction |
|---|---|---|
| $50,000 | $7,500 | $0.31 |
| $100,000 | $15,000 | $0.61 |
| $150,000 | $20,000 | $0.90 |
| $200,000 | $20,000 | $1.17 |
| $250,000 | $20,000 | $1.43 |
| $300,000 | $20,000 | $1.70 |
| $350,000 | $20,000 | $1.96 |
| $400,000 | $20,000 | $2.23 |
| $450,000 | $20,000 | $2.49 |
| $500,000 | $20,000 | $2.76 |

**OPTION – ASSOCIATE + FAMILY**

| Associate Benefit Amount | Spouse Benefit Amount | Child(ren) Benefit Amount | Weekly Payroll Deduction |
|---|---|---|---|
| $50,000 | $20,000 | $5,000 | $0.40 |
| $100,000 | $40,000 | $10,000 | $0.80 |
| $150,000 | $60,000 | $15,000 | $1.19 |
| $200,000 | $80,000 | $20,000 | $1.59 |
| $250,000 | $100,000 | $20,000 | $1.96 |
| $300,000 | $120,000 | $20,000 | $2.34 |
| $350,000 | $140,000 | $20,000 | $2.71 |
| $400,000 | $160,000 | $20,000 | $3.08 |
| $450,000 | $180,000 | $20,000 | $3.45 |
| $500,000 | $200,000 | $20,000 | $3.82 |

## Voluntary Disability: Short-Term and Long-Term
### Insured by Prudential

Short-term disability insurance provides a cash benefit for up to 24 weeks when you are unable to work due to injury, illness, surgery or recovery from childbirth.

If after 24 weeks you are unable to return to work in a full-time capacity, you may be eligible for extended disability benefits if you enroll in the Long-term disability benefits plan. Long-term disability benefits are payable through your Social Security Normal Retirement Age.

| Short-Term Disability | |
|---|---|
| **Weekly benefit amount** | 60% of your weekly earnings, not to exceed $2,000 per week |
| **Elimination period: illness** | 14 days; benefits begin on day 15 |
| **Elimination period: injury** | 14 days; benefits begin on day 15 |
| **Maximum benefit duration** | up to 24 weeks |
| **Pre-existing limitation** | none |

| Long-Term Disability | |
|---|---|
| **Monthly benefit amount** | 60% of your weekly earnings, not to exceed $8,667 per month |
| **Elimination period: illness** | 180 days<br>(after short-term disability ends)* |
| **Elimination period: injury** | 180 days<br>(after short-term disability ends)* |
| **Maximum benefit duration** | Social Security Normal Retirement Age (SSNRA) |
| **Pre-existing limitation** | 3/12** |
| **Evidence of Insurability (EOI)** | Coverage elected during the annual enrollment period is not subject to Evidence of Insurability (EOI) as long as the below criteria has been satisfied:<br>(1) You have not been previously declined; and<br>(2) Your elected benefit amount or increased election amount does not exceed the Maximum Monthly Benefit. |

* Associates not enrolled in the Short-Term Disability plan must satisfy the full 180-day elimination period with benefits payable on the 181st day.

** Benefits may not be paid for any condition treated within 3 months prior to your effective date until you have been covered under this plan for 12 continuous months.

## Voluntary Short-Term Disability Cost
**(weekly payroll deductions)**

Use the chart below to find the cost of Short-Term Disability insurance. Follow the steps below to calculate your coverage cost. Your maximum weekly benefit amount is $2,000. Your coverage level is limited to the salary of $173,333.

| Associate's Age | Rate |
|---|---|
| Under 25 | $.315 |
| 25-29 | $.335 |
| 30-34 | $.325 |
| 35-39 | $.365 |
| 40-44 | $.405 |
| 45-49 | $.480 |
| 50-54 | $.645 |
| 55-59 | $.825 |
| 60-64 | $.825 |
| 65+ | $.945 |

Rates may change as the insured enters a higher age category. Also, rates may change if plan experience requires a change for all insureds.

**How to calculate your total STD Weekly cost**

| | | |
|---|---|---|
| **Step 1** | Indicate your weekly earnings. | = $ |
| **Step 2** | Multiply your weekly earnings by 60% | = $ |
| **Step 3** | If the amount in Step 2 is greater than $2,000, indicate $2,000. Otherwise, indicate the amount from Step 2 | = $ |
| **Step 4** | Multiply the amount in Step 3 by the rate for your age and divide by 10 to obtain your total STD monthly cost. | = $ |
| **Step 5** | Multiply the amount in Step 4 by 12 and divide by 52 to obtain your total STD weekly cost. | = $ |

## Voluntary Long-Term Disability Cost
**(weekly payroll deductions)**

Use the chart below to find the cost of Long-Term Disability insurance. If your salary is not noted, follow the steps below. Your maximum monthly benefit amount is $8,667. All salaries of $173,340 and above have a weekly cost of $19.00.

| Annual Income | Monthly Benefit | LTD Cost |
|---|---|---|
| $12,000 | $600 | $1.32 |
| $13,000 | $650 | $1.42 |
| $14,000 | $700 | $1.53 |
| $15,000 | $750 | $1.65 |
| $20,000 | $1,000 | $2.19 |
| $25,000 | $1,250 | $2.74 |
| $30,000 | $1,500 | $3.29 |
| $35,000 | $1,750 | $3.84 |
| $40,000 | $2,000 | $4.38 |
| $45,000 | $2,250 | $4.93 |
| $50,000 | $2,500 | $5.48 |
| $55,000 | $2,750 | $6.03 |
| $60,000 | $3,000 | $6.58 |
| $65,000 | $3,250 | $7.13 |
| $70,000 | $3,500 | $7.67 |
| $75,000 | $3,750 | $8.22 |
| $80,000 | $4,000 | $8.77 |
| $85,000 | $4,250 | $9.32 |

| Annual Income | Monthly Benefit | LTD Cost |
|---|---|---|
| $90,000 | $4,500 | $9.87 |
| $95,000 | $4,750 | $10.41 |
| $100,00 | $5,000 | $10.96 |
| $105,000 | $5,250 | $11.51 |
| $110,000 | $5,500 | $12.06 |
| $115,000 | $5,750 | $12.60 |
| $120,000 | $6,000 | $13.15 |
| $125,000 | $6,250 | $13.70 |
| $130,000 | $6,500 | $14.25 |
| $135,000 | $6,750 | $14.80 |
| $140,000 | $7,000 | $15.35 |
| $145,000 | $7,250 | $15.89 |
| $150,000 | $7,500 | $16.44 |
| $155,000 | $7,750 | $16.99 |
| $160,000 | $8,000 | $17.54 |
| $165,000 | $8,250 | $18.09 |
| $170,000 | $8,500 | $18.63 |
| $173,340 | $8,667 | $19.00 |

## Supplement Your Medical Coverage

To help you manage out-of-pocket medical costs, Acme offers Voluntary Accident and Critical Illness insurance through Prudential.

### Accident Plan

In the event of a covered accident or injury, this insurance will pay a lump-sum cash benefit to you and your eligible family members who you elect to cover. Accident insurance is NOT medical insurance.

### Critical Illness Plan

Heart attack and stroke are examples of common critical illnesses that often lead to unexpected medical bills. If you are being treated for such a critical illness, shouldn't your primary focus be on getting well--not worrying about how to pay for your care? Critical Illness insurance can help you by paying a lump sum cash benefit to help cover your daily living expenses such as grocery bills, mortgage payments, transportation costs or pay for your out-of-pocket medical costs, including deductibles, copays, and cost-shares. You may choose from $10,000, $20,000, or $30,000 in coverage amounts for yourself, and $5,000, $10,000, or $15,000 for a spouse, not to exceed 50% of associate amount. Critical Illness insurance is NOT medical insurance.

### How to Enroll

To enroll in the Voluntary Accident and/or Critical Illness plan, you will need to complete and submit the "Prudential Group Accident - Critical Illness Enrollment Form" located on Acme Connect or contact your local administrator or HR@brick.com for a copy of this form.

**YOU ENROLL IN CRITICAL ILLNESS AND/OR ACCIDENT INSURANCE**

**SITUATION:**
You have a critical illness such as a heart attack or stroke or accidental injury such as a fractured leg or foot. Your health insurance pays your medical benefits.

**You are treated and recovering – but now the bills are starting to add up:**

- Groceries
- Mortgage/rent
- Transportation costs
- Deductibles
- Copays

**SOLUTION:**
**Critical Illness Insurance and/or Accident Insurance**

- Lump sum payment
- Use as you wish
- Helps to cover medical and non-medical costs
- Pays in addition to health insurance

# Accident Benefits
## Insured by Prudential

| Emergency Treatment | Your Cash Benefit* |
|---|---|
| Ambulance (land or air) | Up to $1,500 |
| Emergency treatment | Up to $200 |
| X-ray | Up to $40 |
| **Fractures** | **Your Cash Benefits*** |
| Ankle | Up to $575 |
| Arm | Up to $1,125 |
| Collarbone | Up to $675 |
| Facial bones | Up to $1,125 |
| Fingers | Up to $125 |
| Foot (excluding toes) | Up to $575 |
| Leg | Up to $4,500 |
| **Dislocations** | **Your Cash Benefits*** |
| Ankle | Up to $1,125 |
| Collarbone | Up to $1,125 |
| Shoulder/Elbow/Hand (except fingers) | Up to $575 |
| Leg/Hip | Up to $3,600 |
| **Specific Injuries** | **Your Cash Benefits*** |
| Blood, plasma | Up to $500 |
| Burns | Up to $15,000 |
| Concussion | Up to $200 |
| Dental services | Up to $200 |
| Lacerations | Up to $600 |
| Traumatic brain injury | Up to $7,500 |
| Surgical benefits | Up to $2,000 |
| **Hospitalization and Ongoing Care** | **Your Cash Benefits*** |
| Admission and daily confinement | Up to $2,000 + up to $600 per day |
| Therapy | Up to $50 per visit/10 visits |
| **Recovery Assistance** | **Your Cash Benefits*** |
| Companion lodging | Up to $200 per day |
| Transportation | Up to $400 per trip |
| **Moving Vehicle Benefits** | **Your Cash Benefits*** |
| Moving vehicle injury/death | Up to $5,000 |
| **Accidental Death and Dismemberment** | **Your Cash Benefits*** |
| Accidental death: you, your spouse or partner, your child(ren) | $75,000, $30,000, $15,000 |
| Dismemberment | Up to $60,000 |

**Benefit payable is dependent on severity and complexity of injury*
*This summary provides an overview of the policy. Full terms of the policy can be found in the policy certificate. Please refer to the disclosure notice on the following page.*

# Critical Illness Benefits
## Insured by Prudential

| Critical Illness for You | Critical Illness for Your Spouse | Critical Illness for Your Child(ren) |
|---|---|---|
| Guaranteed coverage amounts: $10,000, $20,000 or $30,000 | Guaranteed coverage amounts: $5,000, $10,000 or $15,000 (up to 50% of the associate amount) | Guaranteed coverage amounts: $2,500, $5,000, $10,000 (up to 50% of the associate amount) |

| Covered Conditions | Benefit Percentage |
|---|---|
| Heart attack | 100% |
| Sudden cardiac arrest resulting in death | 100% |
| Stroke | 100% |
| Invasive cancer | 100% |
| End stage renal (kidney) disease | 100% |
| Major organ failure (heart, lung, liver, pancreas, intestine) | 100% |
| Arterial/vascular disease | 25% |
| Mitral or aortic valve disease | 25% |
| Non-invasive cancer (in-situ) | 25% |
| Skin cancer (other than melanoma) | $250 per lifetime |
| **Supplemental Conditions** | **Benefit Percentage** |
| Advanced Huntington's disease | 100% |
| Advanced COPD | 100% |
| AIDS | 100% |
| Advanced ALS/Lou Gehrig's disease | 100% |
| Advanced Alzheimer's disease | 100% |
| Advanced Parkinson's disease | 100% |
| Advanced multiple sclerosis | 100% |
| Loss of sight, hearing and/or speech | 50% |
| **Accidental Injuries Benefit** | **Benefit Percentage** |
| Severe burns, permanent paralysis or traumatic brain injuries (includes coma) | 100% |
| **Additional Childhood Diseases** | **Benefit Percentage** |
| Cerebral palsy | 100% |
| Cleft lip, cleft palate | 100% |
| Cystic fibrosis | 100% |
| Down syndrome | 100% |
| Muscular dystrophy | 100% |
| Spina bifida | 100% |
| Type 1 diabetes | 100% |
| **Wellness Benefit** | **Your Cash Benefits*** |
| Receive a cash benefit every year you and any of your covered family members complete a single covered assessment test. | $50 each |

*This summary provides an overview of the policy. Full terms of the policy can be found in the policy certificate*

# Accident and Critical Illness Cost
**(weekly payroll deductions)**

| Accident Plan | |
|---|---|
| **Associate Only** | $2.87 |
| **Associate + Spouse** | $4.74 |
| **Associate + Child(ren)** | $5.21 |
| **Associate + Family** | $7.04 |

| Critical Illness Plan Rates per $1,000 by Age: Associate and Spouse | | | |
|---|---|---|---|
| **< 25** | $.071 | **50 – 54** | $.506 |
| **25 – 29** | $.097 | **55 – 59** | $.684 |
| **30 – 34** | $.127 | **60 – 64** | $.963 |
| **35 – 39** | $.169 | **65 – 69** | $1.324 |
| **40 – 44** | $.248 | **70 – 74** | $2.528 |
| **45 – 49** | $.351 | **75+** | $2.528 |
| **Child** | $.133 | | |

| Critical Illness Premium Calculation | | | |
|---|---|---|---|
| To calculate the weekly payroll deduction, divide your desired benefit by 1,000. Multiply the result by the applicable rate from the above table. | | | |
| **Associate** | divide your desired benefit amount ($30,000, $20,000 or $10,000) by 1,000 | = _____ units × _____ rate | = $ _____ |
| **Spouse** | divide your desired benefit amount ($15,000, $10,000 or $5,000) by 1,000 | = _____ units × _____ rate | = $ _____ |
| **Child** | divide your desired benefit amount ($10,000, $5,000 or $2,500) by 1,000 | = _____ units × _____ rate | = $ _____ |
| | | **Total weekly payroll deduction (estimated)** | **= $**_____ |

*Please note: Spouse coverage is based on the associate's age as of January 1, 2026*

ComPsych GuidanceResources®

# An Overview of Your ComPsych® GuidanceResources Program

**No matter what's going on in your life, ComPsych® GuidanceResources® is here to help**. Personal problems, planning for life events or simply managing daily life can affect your work, health and family. ComPsych® GuidanceResources® is a company-sponsored service that is available to you and your dependents, at no cost, to provide confidential support, resources and information to get through life's challenges. **These confidential services are provided to all Acme associates at no cost.**

## Confidential Counseling on Personal Issues

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

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

## Financial Information, Resources and Tools

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

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

## Legal Information, Resources and Consultation

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

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

## Online Information, Tools and Services

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

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

**WE ARE AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK.**

Call: 800.311.4327
TRS: Dial 711
Online: guidanceresources.com
Your company Web ID: GRS311

# Prudential Beneficiary Advocate
**Powered by ComPsych**

## Prudential Beneficiary Advocate℠

Prudential understands that for those coping with the loss of a loved one, grief counseling can prove invaluable. Grieving loved ones, however, may require many other forms of assistance, including legal and financial services and funeral and estate planning. This is why we offer Beneficiary Advocate by Prudential, a comprehensive program of beneficiary services to help, no matter what the issue. Prudential has a thorough understanding of the unique responsibilities and difficulties in these situations. Whether coping with other family members' grief, struggling with estate-related issues, or coordinating urgent childcare or elder care needs, beneficiaries can benefit from the comprehensive, best-in-class services offered by Prudential in partnership with the worldwide leader in behavioral health solutions, ComPsych® Corporation.

### Comprehensive Beneficiary Support

Beneficiaries can contact ComPsych 24 hours a day, seven days a week. All services are accessible via a dedicated toll-free line and connect you directly to a GuidanceExpert℠, who will conduct an assessment and put you in touch with the appropriate services. Our support includes:

### Emotional Support for Grief and Loss

- Unlimited, 24/7 toll-free phone access to masters-level clinicians for in-the-moment support
- Up to three face-to-face or telephonic counseling sessions with a local provider. Talk to us about:
    - Grief and Loss
    - Anxiety, stress, depression
    - Guidance on returning to work, and more

### Funeral Planning Services

Planning a funeral can feel overwhelming. It is a stressful time, and many decisions need to be made in a short timeframe. Many feel overwhelmed with the process and can be vulnerable to being taken advantage of financially. Final Arrangements services can prevent that. Our Funeral Planning Experts are specially trained to gather information and provide options so you can make the right decisions. Services include:

- Thorough assessment of your needs
- Options, pricing and availability for funeral homes, caskets, urns, cemeteries and more
- Comprehensive referral packet with three detailed referrals for each needed resource

### Online Will Preparation Services

**EstateGuidance** can help you secure your future by overcoming the legal, financial and emotional barriers to estate planning. This online service allows you to create a legally binding Last Will and Testament, Living Will and Final Arrangements document, without the hassle or expense of hiring a lawyer. EstateGuidance walks you through the documentation process and breaks down each step into easy-to understand terms.

### Identity Theft Restoration Services

IDResources® includes unlimited telephonic assistance from our staff of attorneys, financial professionals and counselors. Services are designed to address legal, financial and work/life issues associated with identity loss, assist with restoration of identity, and assist with damage to credit history.

### Financial Planning Services

FinancialPoint® provides objective financial planning guidance to beneficiaries. This simple-to-follow online process makes it easy for individuals to create a financial plan to carry them forward in the wake of a loved one's passing. A FinancialPoint expert reviews the individual's responses; corresponds directly with them for additional information or questions, and provides a detailed, customized personal financial plan.

**WE ARE AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK**.
Call: 800.311.4327
TTY: Dial 711
Online: guidanceresources.com
Your company Web ID: GRS311

# Travel Assistance
**Powered by IMG**



Congratulations, you now have access to IMG's Travel Assistance Services, an indispensable offering available to you and your dependents. IMG has extensive experience handling complex and remote medical transport situations, as well as providing support for travel concerns when they arise. Our team of international, multilingual specialists are accustomed to working across time zones and with different languages and currencies. Utilizing IMG's extensive global network of medical care providers, our onsite 24/7/365 U.S.-based call center is available day or night to provide high-quality care you can depend on.

## EMERGENCY MEDICAL TRANSPORTATION SERVICES

| | |
|---|---|
| Dispatch of a Physician | Repatriation of Remains |
| Emergency Medical Evacuation | Return of Travel Companion |
| $25,000 Emergency Hospitalization | Vehicle Return Services |
| Medical Repatriation | Visit of a Family Member or Friend |

*Only available when traveling outside your home country and the U.S., and can only be used in conjunction with an eligible medical evacuation*

## MEDICAL ASSISTANCE SERVICES

| | |
|---|---|
| Emergency Travel Arrangements | Medical & Dental Referrals |
| Outpatient & Inpatient Care | Prescription Transfer & Shipping |
| Interpretation Services | Telemedicine |
| Medical Monitoring | Replacement of Medical Devices |

## TRAVEL ASSISTANCE SERVICES

| | |
|---|---|
| Emergency Cash Transfer | Lost Luggage/Document Assistance |
| Consulate and Embassy Location | Pet Housing and Return |
| ID Theft Assistance | Pre-Trip Informational Services |
| Legal Referrals | Urgent Message Relay |

## SECURITY ASSISTANCE SERVICES

| | |
|---|---|
| Emergency Political Evacuation/Repatriation | Natural Disaster Evacuation |
| Location Intelligence App | |

Toll-free from within the U.S.:
**+1 (855)847-2194**
From anywhere in the world:
**+1 (317)927-6881**
assist@imglobal.com

# Pet Insurance
## from Nationwide®

With two budget-friendly options, there's never been a better time to protect your pet.

**Our popular My Pet Protection® pet insurance plans now feature more choices and more flexibility**

- **Get cash back on eligible vet bills**: Choose your reimbursement level of 50% or 70%
- **Available exclusively for associates:** Plans with preferred pricing only offered through your company
- **Use any vet, anywhere:** No networks, no pre-approvals

Nationwide®

## Choose your level of coverage with My Pet Protection®

**50%**
**reimbursement**
**$25 - $35/month²**

**70%**
**reimbursement**
**$27 - $47/month²**

## How to use your pet insurance plan

1. Visit any vet, anywhere
2. Submit claim
3. Get reimbursed for eligible expenses

**Get your personalized quote at http://www.petinsurance.com/brick**

¹Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions. Reimbursement options may not be available in all states. ²Starting prices indicated. Final cost varies according to plan, species and ZIP code. Products underwritten by Veterinary Pet Insurance Company (CA), Columbus, OH; National Casualty Company (all other states), Columbus, OH. Agency of Record: DVM Insurance Agency. All are subsidiaries of Nationwide Mutual Insurance Company. Nationwide, the Nationwide N and Eagle, and Nationwide is on your side are service marks of Nationwide Mutual Insurance Company.  21GRP8314

**Associate Discount Program**
**Brought to you by PerkSpot**

# Welcome to PerkSpot!

PerkSpot is a one-stop shop for **exclusive discounts** at some of your favorite national and local merchants!


TRAVEL | COMPUTERS | MOVIES | CELL PHONES | FOOD

1. Start by signing up or logging in at https://acmebrick.perkspot.com
2. Access PerkSpot at work, home, or on the go & browse through thousands of discounts!
3. Keep an eye out for new featured discounts in PerkSpot's weekly email.

*and many more!*

## Medicare Resources

**Brought to you by Boomer Benefits and The Plexus Groupe**

# Boomer Benefits®

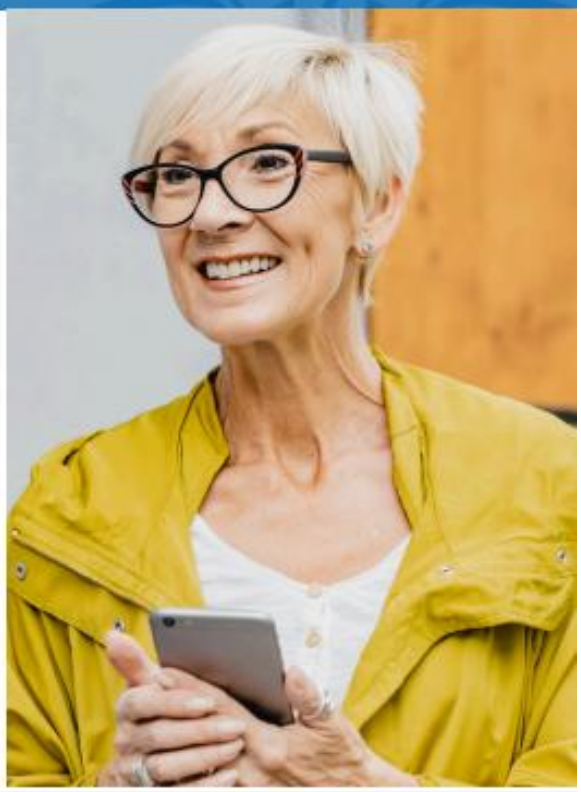
Award-Winning Medicare Insurance Agency

### World-Class Help Navigating Medicare

Founded in 2005, Boomer Benefits is an award-winning insurance agency for national insurance carriers such as Blue Cross Blue Shield, Aetna, Cigna, Mutual of Omaha, and many other A-rated carriers. We are family-owned and licensed in 49 states.

Over the years, we've learned just about everything there is to know about Medicare. We pass that knowledge on to you – absolutely free.

**Employees of Plexus have dedicated contacts at Boomer Benefits: Gabe Gutierrez & Jessica Yant.** Boomer Benefits can help you compare Medigap, Part D, and Medicare Advantage Plan quotes in your zip code.



### Q: How is Boomer Benefits® better than other Medicare brokers?

Our legendary Client Service Team. Our service after we sell a policy is unmatched by anyone in the industry. The number one reason clients stay with us year after year is because of the incredible help they receive from this team at no additional cost.

## Your Dedicated Medicare Experts

Book Appointment Here:

or visit boomerbenefits.com/plexus-groupe

Gabe Gutierrez

Jessica Yant

MERRILL
A BANK OF AMERICA COMPANY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## Benefits OnLine® gives you the power to access your 401(k) account.

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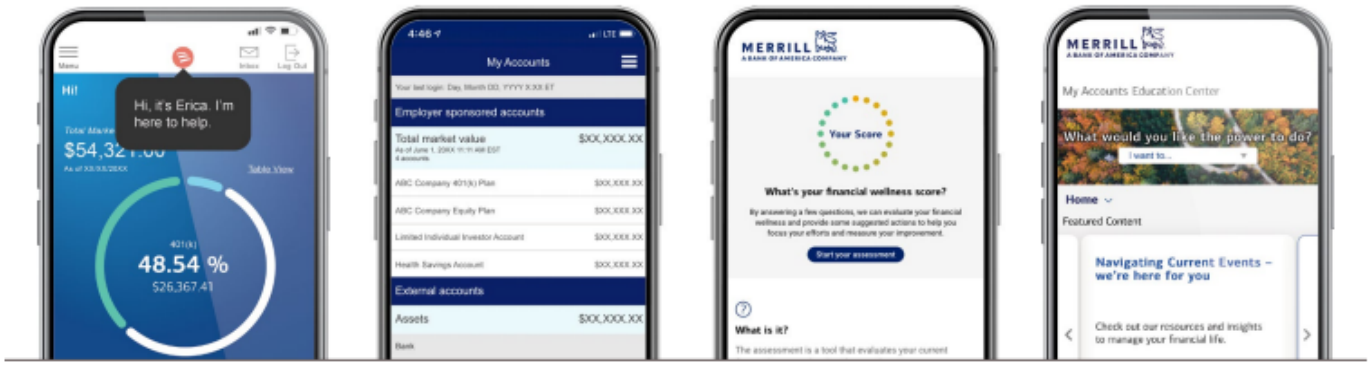
- ✓ Check your account balance and see your progress
- ✓ Manage your contributions and investments

**Ver el sitio en español**
Elija Español en el cuadro
**Preferencia de idioma**.

**Grab your phone and download the app! Your financial future awaits.**

# As life happens... your needs and goals may change.

## Use the Benefits OnLine app* and help build strong financial habits.




### Erica®

**Your virtual financial assistant is ready to help.**

*Check out all that Erica can do for you on the Benefits OnLine app.**

### My Financial Picture®

**All of your financial information — in one place.**

*Use this free, secure service to add your external account information to Benefits OnLine. The more information you add, the more complete your financial picture becomes.*

### Financial Wellness Tracker

**See where you stand financially.**

*Answer a few questions and get a personalized, suggested action plan with steps to help you take control of your finances.*

### Education Center

**Knowledge is key.**

*Explore articles, videos and planning tools for making smart, informed financial decisions.*

* The app is designed to work with most mobile devices in most countries. The mobile feature, Erica, is only available in the English language. Carrier fees may apply. When you use the QRC feature, certain information is collected from your mobile device for business purposes.

**Investing involves risk, including the possible loss of the principal value invested.**

Merrill provides products and services to various employers, their employees and other individuals. In connection with providing these products and services, and at the request of the employer, Merrill makes available websites on the internet, mobile device applications, and written brochures in order to provide you with information regarding your plan. Under no circumstances should these websites, applications, and brochures, or any information included in these websites, applications, and brochures, be considered an offer to sell or a solicitation to buy any securities, products, or services from Merrill or any other person or entity.

## Federal Notices

Federal laws require that Acme Brick provide you with certain notices that inform you about your rights regarding eligibility, enrollment and coverage of health care plans. These notices, SPDs and plan amendments are available in print upon request to the HR department at HR@brick.com.

| Notice | What It Means For You |
|---|---|
| **HIPAA Privacy Notice** | Describes your rights to health privacy |
| **Special Enrollment Rights** | Describes when you can enroll for coverage when you have previously declined coverage. |
| **Premium Assistance Under Medicaid and CHIP** | Provides a list of states that have premium assistance programs to help you pay for medical coverage if you are unable to afford health care coverage premiums. |
| **Family and Medical Leave Act (FMLA)** | If you or a family member is faced with a health condition that causes you to miss work, you may be able to take up to 12 weeks of job-protected time off under the FMLA. |
| **Summary of Benefits and Coverage (SBC)** | Summarizes important information about your health coverage options in a standard format to help you compare each option |
| **Newborns' and Mothers' Health Protection Act** | Describes protections for mothers and their newborn children relating to the length of their hospital stays following childbirth. |
| **Women's Health and Cancer Rights Act of 1998** | Provides information regarding a woman's rights after a mastectomy |
| **Genetic Information Non-Discrimination Act of 2008 (GINA)** | Prohibits employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by the law. |
| **Michelle's Law** | Prohibits group health plans from terminating the coverage of a dependent child who has lost student status as a result of a medically necessary leave of absence. |
| **Consolidated Omnibus Budget Reconciliation Act (COBRA)** | Provides details about how COBRA can provide ongoing health benefits after coverage ends under certain conditions |
| **Your Prescription Drug Coverage and Medicare** | The key purpose of this notice is to advise you that the prescription drug coverage you have under the Acme Brick Health and Welfare Plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2026. (This is known as "creditable coverage.") |
| **Health Insurance Marketplace Coverage Options** | Provides basic information about individual health insurance options that will be available through the Marketplace (also referred to as Exchanges) beginning in 2014. |
| **The "No Surprises Act"** | Provides protection against balance billing and out-of-network cost sharing with respect to emergency services, non-emergency services furnished by non-participating providers at certain participating health care facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services. |

# ACME BRICK

## ANNUAL EMPLOYER NOTICES

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# Acme Brick

# 2026 Annual Employer Notices

## Health Care Reform

The new federal health reform law focuses on establishing new state-based mechanisms for obtaining coverage and for establishing federal standards to oversee benefit designs and costs of coverage. Most of the significant reforms, including Exchanges and guarantee issue requirements, became effective in 2014. Other less significant reforms have already been implemented with the 2011, 2012 and 2013 plan years. Some of the changes to health plan benefits include the elimination of pre-existing conditions, no life-time limits or annual limits on certain plan benefits. Recently, the government removed the requirement of the individual mandate. In other words, individuals are not required to purchase health insurance for 2019 and beyond and will not be subject to a potential penalty if health insurance is not purchased.

## Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act ("HIPAA") deals primarily with how Acme Brick can enforce eligibility and enrollment for health care benefits. Examples of some of the HIPAA requirements include:

- Special enrollment periods are available during the year to you and your eligible dependents (in certain circumstances) that lose other health care coverage if you enroll within 30 days after losing the other health care coverage.
- If you are not enrolled for health care coverage and add an eligible dependent (i.e. marriage), you can enroll yourself and your other eligible dependents within 30 days of the event. If you add an eligible dependent (i.e. birth, adoption or placement for adoption), you can enroll yourself and your newly acquired eligible dependents within 30 days of the event.

The Plan will not base eligibility rules or waiting periods on any of the following factors: health status, mental or physical medical condition, and genetic information, evidence of insurability or disability. Evidence of insurability will not be required when health care coverage is requested during a special enrollment period or during an annual enrollment. However, the Plan may continue to provide for the exclusion of specified health conditions and apply lifetime maximums on either specific benefits or all benefits provided under the Plan. These restrictions also do not preclude the Plan from applying differing benefit levels, benefit schedules or premium rates in certain situations as provided under HIPAA.

**Changing Your Elections**

In general, your annual pre-tax benefit elections are irrevocable for the plan year, January 1, 2026 through December 31, 2026. However, if you experience a Change in Status or special enrollment event that directly affects your eligibility for coverage; you may change your election within 30 days of the event. Under limited circumstances, an election change based solely on a Change in Status must be consistent with your Change in Status (i.e. if a child is born to you, you add coverage for that child).

**In general:**

Change in Status events provide more opportunities for you to make an election change than do special enrollment rights.

If your event could be considered both a Change in Status event and a special enrollment right, you may make any change allowed by either a Change in Status or special enrollment right.

Contact the Acme Brick Benefits Department at 800-792-1234, for more information on the requirements for making an election change based on a Change in Status event or special enrollment right.

Change in Status Events that Permit Election Changes for Health Benefits and Life Insurance Benefits:

- Change in marital status: you may elect coverage for yourself and/or your newly acquired spouse or drop coverage for your spouse if you divorce, legally separate, have your marriage annulled or your spouse dies.
- Change in your number of dependents: you may elect coverage for your newborn, adopted child or a child placed with you for adoption. You may drop coverage if a dependent child dies.
- Change in employment status: you may add or drop coverage consistent with a change in employment status of you, your spouse or dependents that affect the benefit eligibility under this plan or under the employee benefit plan of your spouse or dependents. You, your spouse or dependent experience a change in employment status when any of the following occur and benefit eligibility is affected: begin or end employment, take part in a strike or lockout, begin or return from an approved leave of absence, switch from hourly to salaried, switch from union to non-union or vice versa, reduce or increase the number of hours you work or any similar change that affects your eligibility under the plan.
- Dependent eligibility: you may add or drop your child in the event he or she becomes or ceases to be eligible under the plan.
- Change in residence: you may change your coverage option if you move and it significantly affects your benefit availability.

Additional Change in Status Events that Permit Election Changes for Health Benefits Only:

- Family and Medical Leave Act (FMLA) – certain election changes are permitted when you start an FMLA leave or when you return from an FMLA leave.
- Judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a “qualified medical child support order” or QMCSO) that requires health coverage for an Associate’s child or foster child.
- You, your spouse or your dependent become entitled to or lose eligibility for Medicare or Medicaid.

- You, your spouse or your dependent gain eligibility under another employer's plan.
- A significant change in your cost for health coverage.
- A Change in Status that results in a "special enrollment right" under the Health Insurance Portability and Accountability Act (HIPAA). Please refer to the section below for more information.

You must complete a Change Form and return it to the Acme Brick Benefits Department within 30 days of the Change in Status. If you miss this 30-day period, you will not be able to change your coverage until the following Annual Enrollment period, unless you have another Change in Status that affects your eligibility under the plan.

**Special Enrollment Rights**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may be entitled to enroll in a group health plan at times other than initial eligibility or the Annual Enrollment period. You have special enrollment rights if you and/or your eligible dependents lose other group health coverage, or you gain a new dependent. If either of these events occurs, you must enroll within the 30-day time limit explained here, or you will lose your special enrollment rights for that event.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the medical and/or dental plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of eligibility does not include a loss of coverage that occurs because you fail to pay premiums on a timely basis, if your other coverage is terminated for cause or your voluntary termination of COBRA continuation coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself or your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

You must request enrollment in the medical and/or dental plan no later than 30 days after the event giving rise to your special enrollment right, by completing and returning a new Benefit Enrollment and Change Form. If you fail to request enrollment within the 30-day time period, you and your dependents will lose the special enrollment rights for that event.

If your special enrollment right occurs because you lost other coverage or married, your enrollment is effective on the first day of the month after your Benefits Department receives your properly completed Change Form. If your special enrollment right occurs because of a new dependent child, coverage is effective on the date of the birth, adoption or placement for adoption.

If you or your dependent is eligible, but not enrolled, for health coverage under the Acme Brick medical plan, you and/or your dependent may enroll in the plan if (i) your Medicaid or CHIP coverage is terminated as a result of loss of eligibility or (ii) you and/or your dependent become eligible for premium assistance under Medicaid or CHIP. However, to be eligible for this special enrollment opportunity, you must request coverage under the group health plan within 60 days after the date you and/or your dependent become eligible for premium assistance under Medicaid or CHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends. For more information on Medicaid and CHIP, please see the section below entitled Medicaid/CHIP.

To request enrollment due to a special enrollment right or obtain more information, contact the Acme Brick Benefits Department at 800-792-1234.

## Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

| ALABAMA – Medicaid | ARKANSAS – Medicaid |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) |
| **ALASKA – Medicaid** | **CALIFORNIA – Medicaid** |
| The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility:<br>https://health.alaska.gov/dpa/Pages/default.aspx | Health Insurance Premium Payment (HIPP) Program<br>Website: http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Fax: 916-440-5676<br>Email: hipp@dhcs.ca.gov |
| **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** | **GEORGIA – Medicaid** |
| Health First Colorado Website:<br>https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center:<br>1-800-221-3943/ State Relay 711<br>CHP+: https://hcpf.colorado.gov/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/ State Relay 711<br>Health Insurance Buy-In Program (HIBI):<br>https://www.mycohibi.com/<br>HIBI Customer Service: 1-855-692-6442 | GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: (678) 564-1162, Press 2 |
| **FLORIDA – Medicaid** | **KANSAS – Medicaid** |
| Website:<br>https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>Phone: 1-877-357-3268 | Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884<br>HIPP Phone: 1-800-967-4660 |
| **INDIANA – Medicaid** | **IOWA – Medicaid and CHIP (Hawki)** |
| Health Insurance Premium Payment Program<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>http://www.in.gov/fssa/dfr/<br>Family and Social Services Administration<br>Phone: 1-800-403-0864<br>Member Services Phone: 1-800-457-4584 | Medicaid Website: Iowa Medicaid \| Health & Human Services<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website: Hawki - Healthy and Well Kids in Iowa \| Health & Human Services<br>Hawki Phone: 1-800-257-8563<br>HIPP Website: Health Insurance Premium Payment (HIPP) \| Health & Human Services (iowa.gov)<br>HIPP Phone: 1-888-346-9562 |
| **KENTUCKY – Medicaid** | **MAINE – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br>https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br>KCHIP Website: https://kynect.ky.gov<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms | Enrollment Website:<br>https://www.mymaineconnection.gov/benefits/s/?language=en_US<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-977-6740<br>TTY: Maine relay 711 |
| **LOUISIANA – Medicaid** | **MASSACHUSETTS – Medicaid and CHIP** |
| Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or<br>1-855-618-5488 (LaHIPP) | Website: https://www.mass.gov/masshealth/pa<br>Phone: 1-800-862-4840 TTY: 711<br>Email: masspremassistance@accenture.com |
| **MINNESOTA – Medicaid** | **MISSOURI – Medicaid** |
| Website: https://mn.gov/dhs/health-care-coverage/<br>Phone: 1-800-657-3672 | Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 |
| **MONTANA – Medicaid** | **NEBRASKA – Medicaid** |
| Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084<br>Email: HHSHIPPProgram@mt.gov | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **NEVADA – Medicaid** | **NEW YORK – Medicaid** |
| Medicaid Website: http://dhcfp.nv.gov | Website: https://www.health.ny.gov/health_care/medicaid/ |

| | |
|---|---|
| Medicaid Phone: 1-800-992-0900 | Phone: 1-800-541-2831 |
| **NEW JERSEY – Medicaid and CHIP** | **NEW HAMPSHIRE – Medicaid** |
| Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Phone: 1-800-356-1561<br>CHIP Premium Assistance Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 (TTY: 711) | Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 15218<br>Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov |
| **NORTH CAROLINA – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 | Website: https://www.hhs.nd.gov/healthcare<br>Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **OREGON – Medicaid and CHIP** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website: http://healthcare.oregon.gov/Pages/index.aspx<br>Phone: 1-800-699-9075 |
| **PENNSYLVANIA – Medicaid and CHIP** | **RHODE ISLAND – Medicaid and CHIP** |
| Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **SOUTH DAKOTA - Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |
| **TEXAS – Medicaid** | **UTAH – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Texas Health and Human Services<br>Phone: 1-800-440-0493 | Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/<br>Email: upp@utah.gov<br>Phone: 1-888-222-2542<br>Adult Expansion Website: https://medicaid.utah.gov/expansion/<br>Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/<br>CHIP Website: https://chip.utah.gov/ |
| **VERMONT– Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 | Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid/CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **WISCONSIN – Medicaid and CHIP** | **WYOMING – Medicaid** |
| Website:<br>https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 | Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

| | |
|---|---|
| U.S. Department of Labor<br>Employee Benefits Security Administration<br>www.dol.gov/agencies/ebsa<br>1-866-444-EBSA (3272) | U.S. Department of Health and Human Services<br>Centers for Medicare & Medicaid Services<br>www.cms.hhs.gov<br>1-877-267-2323, Menu Option 4, Ext. 61565 |

## Family and Medical Leave Act (FMLA)

Under the Family and Medical Leave Act (FMLA), you may be eligible for up to 12 weeks of unpaid leave for certain family and medical reasons and continue your benefits at active employee rates. You are eligible for FMLA leave if you have been employed by Acme Brick for at least one year and worked at least 1,250 hours over the previous 12 months.

You may be eligible to take FMLA leave:

- After the birth or adoption of your child or if a child is placed with you for adoption
- To care for your spouse, child or parent who has a serious health condition (including medical conditions resulting from military service)
- If you have a serious health condition that makes you unable to perform your job

You may choose to either continue benefits on the same basis as if you continued working (were an active employee) or revoke your health benefit election (i.e. cancel your benefits) while you are on FMLA leave. If you revoke your benefit election while on FMLA leave, your election can be reinstated when you return to work. If you continue your benefits while on FMLA leave, you must pay your share of the cost for your benefits coverage during your period of FMLA leave. If your leave is unpaid (or paid and does not cover the entire cost), you are responsible for paying your portion of the premiums directly to the insurer. If you fail to make a premium payment, your coverage will be terminated. If your coverage terminates while you are on FMLA leave, your coverage can resume when you return from your FMLA leave of absence. For more information about FMLA leave and your benefit coverage while on FMLA leave, please contact Acme Brick Benefits Department.

## Mental Health Parity Act (1996) (MHPA) and Mental Health Parity and Addiction Equity Act (2008) (MHPAEA)

The Acme Brick medical plan complies with the Mental Health Parity Act of 1996 ("MHPA"). Pursuant to such compliance, the annual and lifetime limits on Mental Health Benefits, if any, will not be less than the annual and lifetime plan limits on other types of medical and surgical services (if any limits apply). The plan does utilize cost containment methods, applicable for Mental Health Benefits, including cost-sharing, limits on the number of visits or days of coverage, and other terms and conditions that relate to the amount, duration and scope of Mental Health Benefits.

MHPA and MHPAEA only apply to plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully insured arrangements. MHPAEA also applies to health insurance issuers who sell coverage to employers with more than 50 employees. Take out if not applicable.

## IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.

Since this policy isn't health insurance, it doesn't have to include most federal consumer protections that apply to health insurance.

### Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

### Questions about this policy?

- For questions or complaints about this policy, contact your state Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (**naic.org**) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

## Transparency in Coverage (TiC) Machine-Readable Files (MRF) Notice

The Transparency in Coverage (TiC Regulations) and the Consolidated Appropriations Act of 2021 (CAA) (collectively "transparency requirements") impose certain obligations on group health plans, health insurers, and health care providers.

Two of these requirements became effective July 1, 2022:

- Group health plans must make public a MRF with in-network provider rates for covered items and services ("In-network Rate Disclosures);

- Group health plans must make public a MRF with out-of-network allowed amounts and billed charges for certain covered items and services ("Out-of-network Rate Disclosures).

By clicking here, https://www.bcbstx.com/member/policy-forms/machine-readable-file you can find our health plan's in-network and out-of-network rate disclosures as required under the TiC regulations.

## Newborns' and Mothers' Health Protection Act (NMHPA)

The Acme Brick medical plan will comply with all required provisions of the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) with respect to health benefits provided under this plan. The plan will not 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. You only need to pre-certify maternity hospital stays if the hospital stay will be longer than the periods specified above. However, you must still pre-certify any hospital admission during your pregnancy that is not due to delivery or is in excess of the applicable timeframes outlined above. In addition, the plan will not require that a provider obtain authorization from the plan and insurer for prescribing a length of stay not in excess of the above periods. However, the NMHPA generally does not prohibit the mother's or newborn's attending provider, after consulting with and obtaining consent from the mother, from discharging the mother and/or her newborn earlier than 48 hours (or 96 hours as applicable).

## Women's Health and Cancer Rights Act (WHCRA)

The Acme Brick medical plan complies with all required provisions of the Women's Health and Cancer Rights Act of 1998 (WHCRA) with respect to health benefits provided under this plan. The plan will cover certain breast reconstruction and other benefits in connection with a mastectomy. If you elect breast reconstruction in connection with a mastectomy, coverage is available in a manner determined in consultation with you and your physician for (1) all stages of reconstruction of the breast on which the mastectomy was performed, (2) surgery and reconstruction of the other breast to produce a symmetrical appearance, (3) prosthesis and (4) treatment of physical complications for all stages of mastectomy, including lymphedemas. Such coverage remains subject to the terms of the Plan, including normal deductible, copay and coinsurance provisions.

## Genetic Information Nondiscrimination Act of 2008 (GINA)

The Acme Brick medical plan will comply with all required provisions of GINA with respect to health benefits and coverage under this plan. The plan will not discriminate on the basis of genetic information, including information about manifestation of a disease or disorder in a family, in addition to information about genetic tests. Furthermore, genetic information will not be requested or required for underwriting purposes or before enrollment, participants and covered dependents will not be required to undergo genetic testing and genetic information will not be used to adjust premiums or contributions for groups under the Acme Brick medical plan. However, the plan and/or employer may use, in accordance with GINA, a minimum necessary amount of genetic testing results in order to make a determination about a claim payment where such information is necessary and/or required. For more information about GINA, please contact your Benefits Department.

## Michelle's Law

Subject to future regulations and the Affordable Care Act, the Acme Brick medical plan will comply with all required provisions of Michelle's Law with respect to health benefits provided under this plan to dependent children over the age of 18 who are enrolled in an institution of higher education on a full-time basis. If the dependent child is enrolled on a full-time basis and subsequently loses his/her full-time status at his/her institution of higher education as a result of taking a "medically necessary leave of absence" (as defined under Michelle's Law) due to a serious illness or injury, coverage for the dependent under the Acme Brick medical plan will not terminate until the earlier of (i) the date that is one year after the first day of the medically necessary leave of absence or (ii) the date coverage would otherwise terminate under the plan. The student/dependent on leave is entitled to the same benefits as if he/she had not taken a leave. If coverage changes during the student's leave, then this law applies in the same manner as the prior coverage.

Please note that under the Affordable Care Act, group health plans and issuers are generally required to provide dependent coverage to age 26 regardless of student status of the dependent. Nonetheless, under some circumstances, such as a plan that provides dependent coverage beyond age 26, Michelle's Law provisions may apply. For more information about Michelle's Law and your dependent's benefit coverage under Michelle's Law, please contact the Acme Brick Benefits Department.

## Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

**What is "balance billing" (sometimes called "surprise billing")?**

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a

service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

**You're protected from balance billing for:**

**Emergency services**

If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

**Certain services at an in-network hospital or ambulatory surgical center**

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

**You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.**

**When balance billing isn't allowed, you also have these protections:**

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

**If you think you've been wrongly billed, contact the No Surprises Help Desk at 1-800-985-3059**

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

## Consolidated Omnibus Budget Reconciliation Act (COBRA)
## Important Information about Your Right to COBRA Continuation Coverage

This contains important information about your right to group health plan continuation coverage, which is a temporary extension of coverage under the Plan after you (and/or your qualified dependent) would otherwise lose group health coverage under the Plan. The right to this continuation coverage (COBRA continuation coverage) was created by Federal law under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA, you may elect to temporarily continue your group health coverage for yourself and any eligible dependents covered by the Acme Brick group health plans on the day your (or your qualified dependents) group health benefits ceased because of a qualifying event. You and your eligible dependents are eligible to elect COBRA continuation coverage even if you (or they) have health coverage under another group health plan. Please read this section carefully as it generally explains COBRA continuation coverage, when it may be available to you and your eligible dependents and what you (and they) need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 Benefits Department.

**Eligibility for COBRA Continuation Coverage**

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

qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage.

**Qualifying Events and COBRA Continuation Coverage**

The qualifying events for COBRA continuation coverage and the maximum COBRA continuation coverage periods are shown in the charts that follow.

**Employee COBRA Continuation Coverage**

If you are an employee of Acme Brick and are covered by Acme Brick's health plan you have the right to COBRA continuation coverage (for the period stated) if you lose coverage due to the following qualifying events:

| Qualifying Event | Maximum Continuation Period |
|---|---|
| Termination of your employment (for reasons other than gross misconduct) | 18 months |
| Reduction in your hours of employment with loss of eligibility for benefits | 18 months |

**Spouse of an Employee COBRA Continuation Coverage**

If you are the spouse of an employee of Acme Brick and are covered by Acme Brick's health plan, you have the right to COBRA continuation coverage (for the period stated) if you lose coverage due to the following qualifying events:

| Qualifying Event | Maximum Continuation Period |
|---|---|
| The employee's termination of employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment with loss of eligibility for benefits | 18 months |
| The death of the employee | 36 months |
| Divorce or legal separation from the employee | 36 months |
| The employee's entitlement to Medicare | 36 months |

**Dependent Children of an Employee COBRA Continuation Coverage**

Dependent children of an employee of Acme Brick who are covered by Acme Brick's health plan have the right to COBRA continuation coverage (for the period stated) if they lose coverage due to the following qualifying events:

| Qualifying Event | Maximum Continuation Period |
|---|---|
| The employee's termination of employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment with loss of eligibility for benefits | 18 months |
| The death of the employee | 36 months |
| The employee's divorce or legal separation | 36 months |
| The employee's entitlement to Medicare | 36 months |
| Loss of eligible dependent status (i.e., reach maximum age, lose full-time student status) | 36 months |

The maximum period of COBRA continuation coverage is measured from the date of the loss of coverage due to the applicable qualifying event specified above.

The plan will offer COBRA continuation coverage to a qualified beneficiary only after the Acme Brick Benefits Department has been properly notified that a qualifying event has occurred.

You must notify the Acme Brick Benefits Department within sixty (60) days of the following qualifying events: divorce or legal separation of the employee; spouse or a dependent child losing eligibility for coverage as a dependent under the plan, or Medicare entitlement. You must provide this notice to the Acme Brick Benefits Department within the sixty (60) day deadline or your right to COBRA continuation coverage will be lost and will not be reinstated. Notice requirements are detailed below.

A special rule applies if you drop coverage for your spouse and/or eligible dependent children because you are planning to divorce. In such a case, your spouse and/or dependent children who had previously been covered under the plan would be entitled to elect COBRA continuation coverage for up to thirty-six (36) months from the date the divorce is final, but only if the Acme Brick Benefits Department is notified of the divorce within sixty (60) days from the date of final judgment. No retroactive coverage before the date of divorce is available.

If it is determined that an individual is not eligible for COBRA continuation coverage, the COBRA administrator, WEX Health, Inc., will notify such individual of his or her failure to qualify for COBRA continuation coverage. This notice will explain why the individual is not entitled to COBRA continuation coverage and will be sent within fourteen (14) days after the receipt of the individual's notice of a qualifying event.

**Subsequent Qualifying Event**

If a subsequent qualifying event that is not your termination of employment or reduction in work hours (such as your divorce, legal separation, your death or your dependent child ceasing to be eligible under the plan) occurs during an initial eighteen (18) month period of coverage, COBRA continuation coverage may be extended for your eligible dependents who are qualified beneficiaries for up to a maximum period of thirty-six (36) months measured from the date of the first qualifying event. An event shall not be a subsequent qualifying event unless that event would cause a loss of coverage under the Plan independent of the initial qualifying event. The covered employee will not be eligible for an extension of your maximum 18-month period of COBRA continuation coverage for a subsequent qualifying event.

Notice of a subsequent qualifying event must be given to the COBRA administrator, WEX Health, Inc., within a maximum of sixty (60) days in order to extend COBRA continuation coverage. If you fail to inform the COBRA administrator, WEX Health, Inc., you will lose your right to extend your COBRA continuation coverage and this right will not be reinstated. Notice requirements are detailed below. Please see the special COBRA continuation coverage for Disabled Persons section of this guide for information on disability as a subsequent qualifying event.

**Notice Requirements**

In most cases, the COBRA administrator, WEX Health, Inc., will notify you of your right to elect COBRA continuation coverage. However, if your eligible dependent has a qualifying event as a result of your divorce, legal separation, Medicare entitlement or lose their status as a dependent, you or your covered dependent must properly notify the COBRA administrator, WEX Health, Inc., within a maximum of sixty (60) days of the qualifying event. In addition, if you have a child born, legally adopted or placed for adoption with you during your period of COBRA continuation coverage, you must notify the COBRA administrator, WEX Health, Inc., within sixty (60) days of the event in order to cover the child.

Notice must be submitted to the COBRA administrator, WEX Health, Inc., at P.O. Box 2079 Omaha, NE 68103-2079 on the written form approved by the Benefits Department. The form must be completed and submitted to the COBRA administrator, WEX Health, Inc., before the end of the applicable deadline. The forms, information and deadlines for certain events are outlined in the table below.

| Event Requiring Notice | Deadline for Notice |
|---|---|
| Divorce or Legal Separation | Within 60 days from date of final court judgment |
| Dependent becomes ineligible under the plan | Within 60 days from date of ineligibility |
| Medicare entitlement | Within 60 days from date of entitlement |
| Determination of disability | Within 60 days of disability determination and before the end of the maximum 18-month COBRA continuation coverage period |
| Determination of non-disability status | Within 30 days of the Social Security Administration's determination of non-disability |
| Marriage | Within 31 days from the date of marriage |
| Birth, Adoption or Placement for Adoption | Within 60 days from date of the event |

Failure to properly provide the required notice may result in loss of any COBRA continuation right and, if lost, this right will not be reinstated.

The COBRA administrator, WEX Health, Inc., is the designated recipient for all COBRA continuation coverage notices. They may be reached at: 866-451-3399, P.O. Box 2079 Omaha, NE 68103-2079.

**Electing COBRA Continuation Coverage**

Once the COBRA administrator, WEX Health, Inc., receives notice that a qualifying event has occurred, COBRA continuation coverage will then be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. However, you may elect COBRA continuation coverage on behalf of your spouse and parents may elect COBRA continuation coverage on behalf of their children.

If you wish to elect COBRA continuation coverage, you must notify the COBRA administrator, WEX Health, Inc., within a maximum of sixty (60) days of the later of: (i) the date of the qualifying event or (ii) the date you received your COBRA notice. If you choose to continue benefits for yourself and your eligible dependent, before the maximum sixty (60) day election deadline, your coverage will continue uninterrupted. If you (or your eligible dependent) fail to elect COBRA continuation coverage within the maximum sixty (60) days after you are notified by the COBRA administrator, WEX Health, Inc., you will lose your right to COBRA continuation coverage and that right will not be reinstated.

You must also keep the COBRA administrator, WEX Health, Inc., informed of all the information needed to meet its obligation of both providing notice to you of your right to COBRA continuation coverage and providing the actual COBRA continuation coverage. Such information includes your current contact information and administrative information about yourself, your spouse and/or dependents. You or your spouse's election to take COBRA continuation coverage can also be an election to cover all the other qualified beneficiaries in the family, unless the election is specific as to which qualified beneficiaries are to be covered.

You must notify the COBRA administrator, WEX Health, Inc., to request alternate coverage if you move outside the service area of the benefit network for your elected coverage. Alternate coverage will be made available (if available) to you not later than the date of the relocation or the first day of the month following the month in which the request is made.

**Health Care Exchange - Notice**

There may be other coverage options for you and your family. For example, you will be able to buy coverage through the Health Insurance Marketplace during the Marketplace's open enrollment period. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

**Special Enrollment Events and COBRA**

If you have a child born to, adopted or placed for adoption with you during your period of COBRA continuation coverage, you must notify the COBRA administrator, WEX Health, Inc., and elect coverage within sixty (60) days of the child's birth, adoption or placement for adoption. If you get married during your COBRA continuation coverage, you may add your new spouse to your COBRA continuation coverage if you notify the COBRA administrator, WEX Health, Inc., within thirty-one (31) days of the date of the marriage. A new dependent may be a participant under this coverage for the remainder of your maximum COBRA continuation period (eighteen (18), twenty-nine (29) or thirty-six (36) months, depending on the applicable qualifying event).

**Cost and Payment of COBRA Premiums**

You must pay the full cost for COBRA continuation coverage (plus a two percent (2%) administrative fee). the COBRA administrator, WEX Health, Inc., will determine this cost, but it generally cannot exceed one hundred two percent (102%) of the plan's cost for providing coverage to similar situated covered active employees and their covered dependents. COBRA premiums are subject to change annually. If you and your covered dependents are receiving an additional eleven (11) months of COBRA continuation coverage due to disability as the qualifying event, the COBRA administrator, WEX Health, Inc., will determine COBRA premium which will not exceed one hundred fifty percent (150%) of the plan's cost for providing coverage, if the disabled qualified beneficiary is part of the COBRA continuation coverage group or one hundred two percent (102%) if the disabled qualified beneficiary is not receiving COBRA continuation coverage.

Once an election for COBRA continuation coverage is made, you (or your covered dependents) have a maximum of forty-five (45) days from the date of election to pay the premium for the current month and any retroactive COBRA premiums then due for the elected coverage. Although coverage is retroactive to the date of loss of coverage due to the initial qualifying event, no COBRA continuation coverage benefits will be paid until this first COBRA premium is received by the COBRA administrator, WEX Health, Inc.. If payment is not received within the forty-five (45) day period, then coverage will either be revoked retroactively or not become effective. You will lose your right to COBRA continuation coverage and it will not be reinstated.

All subsequent COBRA premium payments are due on the first day of the month. The plan allows a thirty (30) day grace period for payment of required COBRA premiums (except the first payment previously discussed). Even if you do not receive a bill, you must still submit your COBRA premium payments within the required time period. ***The thirty (30) day grace period does not apply to the forty-five (45) day period for payment of the initial COBRA premium.*** If your COBRA premium payment is not postmarked by the last day of the grace period, your COBRA continuation coverage will end as of the last day of the last month for which a full COBRA premium payment was made.

If timely payment of the COBRA premium is made to the plan in an amount that is not more than fifty dollars ($50) or ten percent (10%) less than the required COBRA premium payment, then the amount paid is deemed to satisfy the plan's requirement for full COBRA premium payment, unless the COBRA administrator, WEX Health, Inc., notifies the qualified beneficiary of the amount of the deficiency and allows thirty (30) days for payment of the deficiency to be made.

COBRA premiums can be paid by you or by a third party on your behalf. Here are a few other details about COBRA premium payments you need to be aware of:

- No late or reminder notices will be sent for payments that have not been made.
- Once COBRA continuation coverage is terminated, it cannot be reinstated.
- All terms and conditions that apply to active participants in the plan are also applicable to COBRA continuation coverage participants.
- All rules and procedures for filing and determining benefit claims and appeals under the plan that apply to active employees also apply to COBRA continuation coverage.

**Trade Act Credit**

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PGBC) (eligible individuals) and pay for health coverage. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at (866) 628-4282. TTD/TTY callers may call toll-free at (866) 626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

**Responses to Information Regarding a Qualified Beneficiary's Right to Coverage**

Upon request, the plan must inform health care providers regarding the qualified beneficiary's right to coverage during the applicable grace periods. In addition, the plan is required to respond to inquiries from health care providers regarding the qualified beneficiary's right to coverage during the election period and his or her right to retroactive coverage if COBRA continuation coverage is elected.

**Changes in Benefits under COBRA**

If you or any covered dependents elect COBRA continuation coverage, benefits will be the same as were in effect at the time of your qualifying event. You will be able to change your plan coverage option during annual enrollment to the same extent as similarly situated active employees. If the group health plan benefits of active employees change, benefits for qualified beneficiaries on COBRA continuation coverage will also change in the same manner.

**Special COBRA Continuation Coverage for Disabled Persons**

If you (and your covered dependents) are receiving eighteen (18) months of COBRA continuation coverage and your qualifying event is a termination of employment or a reduction of hours, your maximum COBRA continuation coverage period may be extended by eleven (11) months to up to a maximum of twenty-nine (29) months in total provided the following requirements are met:

- The Social Security Administration determines that you (or your dependent who is a qualified beneficiary) are disabled within the meaning of the Social Security Act;
- This disability exists as of the date of the qualifying event or at any time during the first sixty (60) days of COBRA continuation coverage following the qualifying event; and
- The disability lasts at least until the end of the eighteen (18) month period of COBRA continuation coverage.

Notice of the determination of disability under the Social Security Act must be provided to the COBRA administrator, WEX Health, Inc., within the initial eighteen (18) month coverage period and within sixty (60) days after the latest of: (1) the date of the Social Security Administration determination of disability; (2) the date on which the qualifying event occurs; (3) the date on which the qualified beneficiary loses coverage; or (4) the date on which the qualified beneficiary is informed of the obligation to provide the notice of disability. If you fail to properly notify the COBRA administrator, WEX Health, Inc., within the deadline above, you will lose your right to the extension of COBRA continuation coverage and this right will not be reinstated. Please refer to the Notice Requirements section above for information about proper notice to the plan.

If the Social Security Administration determines later that the qualified beneficiary is no longer disabled, the COBRA administrator, WEX Health, Inc., must be properly notified within thirty (30) days of the Social Security Administration's determination. This notice will end the extended COBRA continuation coverage for all qualified beneficiaries within the coverage group. Failure to notify the COBRA administrator, WEX Health, Inc., that a qualified beneficiary is no longer disabled will result in termination of COBRA continuation coverage for all qualified beneficiaries within the coverage group effective on the date of the Social Security Administration determination and such coverage will not be reinstated. When the disabled qualified beneficiary becomes eligible for Medicare, the COBRA administrator, WEX Health, Inc., must be properly notified to end the extended coverage for the affected disabled qualified beneficiary. Please refer to the Notice section above for information about proper notice to the plan.

**COBRA Continuation Coverage and Medicare**

If your dependent is receiving COBRA continuation coverage and you become entitled to Medicare benefits, your coverage will end but COBRA continuation coverage for your qualified dependents may continue for up to thirty-six (36) months measured from the date of the initial qualifying event.

In addition, if you become entitled to Medicare and then later terminate employment (for reasons other than gross misconduct) or have a reduction in hours, your qualified dependents who are eligible for COBRA continuation coverage will be eligible for thirty-six (36) months of COBRA continuation coverage measured from the date you became entitled to Medicare. However, you will only be eligible for eighteen (18) months of COBRA continuation coverage measured from the qualifying event.

**Termination of COBRA Continuation Coverage**

COBRA continuation coverage shall not be provided beyond the earliest of the following dates:

- The date the maximum COBRA continuation coverage period expires based upon the qualifying event;
- The date the plan is terminated, and no other group health plan is provided to active employees;

- The last day of the month preceding the month for which the qualified beneficiary fails to pay the premium for COBRA continuation coverage by the last day of the grace period;
- The date the qualified beneficiary first becomes entitled to Medicare, including Medicare entitlement due to End Stage Renal Disease (ESRD), after the person elects COBRA continuation coverage;
- The date that initial payment is not received within a maximum of forty-five (45) days after the election of COBRA continuation coverage is made;
- The date the qualified beneficiary first becomes covered under another group health plan or policy after the date the person elects COBRA continuation coverage; or
- For a disabled qualified beneficiary receiving COBRA continuation coverage during the eleven (11) month disability extension period (and their covered family members), the date the disabled person receives a final determination by the Social Security Administration that he or she is no longer "disabled." This final determination shall end COBRA continuation coverage for all qualified beneficiaries as of the later of either: (a) the first day of the month following thirty (30) days from the final determination date; or (b) the end of the COBRA continuation coverage period based on the initial qualifying event without regard to a disability extension.

If your COBRA continuation coverage is terminated for any of the reasons noted above, your coverage will end and will not be reinstated.

In the event that your COBRA continuation coverage is terminated before the end of the maximum coverage period, the COBRA administrator, WEX Health, Inc., will notify you of the termination of your coverage as soon as administratively possible. This notice will explain why and when COBRA continuation coverage has ended.

**Contact Information for COBRA Administrator**

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 the Plan Informed**

In order to protect your family's rights, you should keep the COBRA administrator, WEX Health, Inc., informed of any changes in the address of family members. You should also keep a copy of all COBRA notices that you receive or send in your own records.

**Plan Contact Information**

Information about the plan may be obtained by contacting the COBRA administrator, WEX Health, Inc., at P.O. Box 2079 Omaha, NE 68103-2079.

## Notice of Privacy Practices

### Your Information. Your Rights. Our Responsibilities.

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.**

### Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

**Get a copy of health and claims records**

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct health and claims records
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

**Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

## Our Uses and Disclosures

## How do we typically use or share your health information?

We typically use or share your health information in the following ways.

**Help manage the health care treatment you receive**

We can use your health information and share it with professionals who are treating you.

*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

**Run our organization**

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

*Example: We use health information about you to develop better services for you.*

**Pay for your health services**

We can use and disclose your health information as we pay for your health services.

*Example: We share information about you with your dental plan to coordinate payment for your dental work.*

**Administer your plan**

We may disclose your health information to your health plan sponsor for plan administration.

*Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

## How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests and work with a medical examiner or funeral director**

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

## Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, and we will provide you with a copy.

If you have any questions about this Notice, please contact the Privacy Officer at Acme Brick. The contact information for the Privacy Officer is as follows:

Privacy Officer

Acme Brick

3024 Acme Brick Plaza

Fort Worth, TX 76109

## Important Notice from Acme Brick About Your Prescription Drug Coverage and Medicare

**Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Acme Brick and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.**

**There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:**

**1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

**2. Acme Brick has determined that the prescription drug coverage offered by the Acme Brick medical plan(s) 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.**

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## When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Acme Brick coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Acme Brick coverage, be aware that you and your dependents may not be able to get this coverage back.

## 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 coverage with Acme Brick and do not 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 Acme Brick's Benefits Department at 800-792-1234 for further information. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Acme Brick changes. You also may request a copy of this notice at any time.

**CMS Form 10182-CC Updated April 1, 2011** - According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage: Visit www.medicare.gov. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Acme Brick
Position/Office: Benefits Department
3024 Acme Brick Plaza
Fort Worth, TX 76109
800-792-1234

# Health Insurance Marketplace Coverage Options and Your Health Coverage

**PART A: General Information**

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

**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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 8.39% of your annual household income in 2024 or 9.02% in 2025, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 8.39% in 2024 or 9.02% in 2025 of the employee's household income. An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

**When Can I Enroll in Health Insurance Coverage through the Marketplace?**

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. **The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

**What about Alternatives to Marketplace Health Insurance Coverage?**

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

**How Can I Get More Information?**

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Acme Brick's Benefits Department.

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

**PART B: Information About Health Coverage Offered by Your Employer**

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

| | |
|---|---|
| 3. Employer name<br>Acme Brick | 4. Employer Identification Number (EIN)<br>Contact your Benefits Department |
| 5. Employer address<br>3024 Acme Brick Plaza , «Employer-Address2» | 6. Employer phone number<br>800-792-1234 |
| 7. City, 8. State, 9. Zip Code<br>Fort Worth, TX 76109 | |
| 10. Who can we contact about employee health coverage at this job?<br>Acme Brick's Benefits Department | |
| 11. Phone number (if different from above) | 12. Email address (optional) |

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

- As your employer, we offer a health plan to:

  ☑Full-time employees working 30 or more hours per week

- With respect to dependents:

  ☑

  We do offer coverage. Eligible dependents are:

  - Your legal spouse or your domestic partner

- Your children up to age 26, including your natural–born children, stepchildren, any children who are under your legal guardianship, who are in your custody under an interim court order of adoption, or who are placed with you for adoption
- Your children, of any age, who are physically or mentally disabled and incapable of supporting themselves, and can be claimed as a dependent on your U.S. federal income tax return

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

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

## Notice Regarding Wellness Program

Acme Brick is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

Employees who choose to participate in the wellness program will receive an incentive of lower medical plan contributions for completing an annual physical, being nicotine free* and submitting a Wellness Incentive Affidavit. Although you are not required to participate, only employees who do so will receive lower medical plan contributions.

You may request a reasonable accommodation or an alternative standard by contacting the Acme Brick Benefits Department at 800-792-1234.

**Protections from Disclosure of Medical Information**

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Acme Brick may use aggregate information it collects to design a program based on identified health risks in the workplace, Acme Brick Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) Acme Brick Wellness Plan Administrator in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Acme Brick Benefits Department at 800-792-1234.

*Nicotine free: In order to be considered nicotine free, you must not be using any nicotine products, or you must complete the no cost tobacco cessation program through BlueCross annually. If you complete to tobacco cessation program in lieu of being nicotine free, you must submit proof of completion of the program from BlueCross with your Wellness Incentive Affidavit by December 1st of each year or within 31 days of your insurance effective date. However, if you complete the tobacco cessation program after the dates above, you should submit the proof of program completion to HR@brick.com. If you completed the annual physical requirement and submitted your affidavit verifying completion timely, you will be moved to the Select rates retroactive to date your coverage was effective for the current plan year .

(January 1st or the date you were 1st covered after January 1st).

## Important Contacts

| Coverage | Administrator | Phone | Email/Website |
|---|---|---|---|
| **Human Resources** | Acme Brick | 800.792.1234 | HR@brick.com |
| **Medical Benefits** | BlueCross BlueShield Of Texas | 800.521.2227 | bcbstx.com |
| **Pharmacy Benefits** | Express Scripts | 855.686.9784 | express-scripts.com |
| **Smoking Cessation** | BlueCross BlueShield Of Texas | 877.806.9380 | bcbstx.com |
| **Telemedicine/ Virtual Visits** | Teladoc Health | 800.TELADOC | TeladocHealth.com |
| **Diabetes Management** | Livongo by Teladoc Health | 800.945.4355 | Livongo.com |
| **Accident Benefits** | Prudential | 877.507.4778 | mybenefits.prudential.com |
| **Critical Illness Benefits** | Prudential | | |
| **Flexible Spending Accounts (FSA)** | Wex Health | 866.451.3399 | WexInc.com |
| **Dental Benefits** | Cigna | 800.244.6224 | mycigna.com |
| **Vision Benefits** | Davis Vision | 800.999.5431 | DavisVision.com |
| **Life/AD&D Benefits** | Prudential | 877.507.4778 | mybenefits.prudential.com |
| **Disability Benefits** | Prudential | | |
| **Employee Assistance Program (EAP)** | ComPsych and Guidance Resources | 855.327.4463 | GuidanceResources.com<br>Web ID: GRS311 |
| **Pet Insurance** | Nationwide | 877.738.7874 | petinsurance.com/brick |
| **Associate Discount Program** | PerkSpot | n/a | acmebrick.perkspot.com |
| **Retirement Savings** | Bank of America Merrill Lynch | 800.228.4015 | benefits.ml.com<br>(Acct # 605900) |
| **Pension Plan** | Berkshire Hathaway Consolidated Pension Plan | 877.459.2403 | eepoint.com/bhcpp |


ACME
BRICK
"THE BEST THING TO HAVE AROUND YOUR HOUSE"