Oldcastle BuildingEnvelope®

2022

Benefits Guide

Table of Contents

This guide is intended to provide a high-level overview and general information of your benefit options for 2022. For details about your benefits, refer to your summary plan descriptions (available through your Human Resources/Benefits Department and online at **www.myOBEbenefits.com**). We have made every effort to report the information in this guide accurately. This guide does not include all of the terms, coverage, exclusions, limitations and conditions of the plan document. However, if a discrepancy exists between this guide and the plan document, the plan document will govern. This guide does not imply a guarantee of employment or a continuation of benefits. Oldcastle BuildingEnvelope reserves the right to suspend, change or amend these benefits at any time, for any reason for any active, inactive, retired, disabled or terminated employees.

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

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

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

As an employee of the company, you have three opportunities to enroll in the company-sponsored benefit plans:

1 New Hire Enrollment Period

For employees hired January 1st through December 31st

As a new hire you are eligible for benefits the 1st of the month following 60 days from the date you start working for Oldcastle BuildingEnvelope ("the Company"). As a new hire you have up to 30 days from your eligibility date to elect coverage.

If you fail to enroll in a timely manner or complete all the necessary enrollment steps, you will forfeit your right to coverage under this plan until the next Open Enrollment period, which is not until the Fall of 2022. The only exception to this rule is if you experience a qualifying status change as outlined below, then you may make a change in your coverage within 60 days of the qualifying life event.

2 Annual Enrollment Period – Open Enrollment

For employees making annual elections for the upcoming plan year. An open enrollment window is held each fall.

Oldcastle BuildingEnvelope Annual Open Enrollment for your Health and Welfare Benefits is held each year. Employees have the option to keep, add, drop, or make changes to their benefit elections.

A positive enrollment takes place each year, which mean you must make an active election in order to enroll and make health insurance and FSA election for the upcoming plan year. Benefit elections will not carry over from the prior year.

You must enroll in the benefit plans you want for the upcoming plan year.

IMPORTANT: Enrollment does not carry forward year to year. Enrollment must be completed during the open enrollment window. If you do not go online or call the Oldcastle BuildingEnvelope Benefits Helpline to enroll in the Healthcare Plan, you will NOT be covered under the Oldcastle BuildingEnvelope Healthcare Plan in the upcoming plan year.

A Spousal Surcharge Waiver MUST be completed each year during Open Enrollment, the waiver does not carry forward year to year.

3 Special Enrollment Period – Qualifying Event

For employees making mid-year changes to their benefit elections due to qualifying events.

Benefits Overview

Oldcastle BuildingEnvelope is pleased to provide you with a comprehensive benefits program. The Oldcastle BuildingEnvelope Benefits Program offers a variety of benefit options to meet the diverse needs of our employees.

Health Plan—BCBSTX is the claims administrator for the Oldcastle BuildingEnvelope medical plans utilizing the Blue Cross Blue Shield network. You can choose to enroll in one of the medical plans:

1. PPO (Preferred Provider Organization)
2. HDHP (High Deductible Health Plan)

Prescription, Dental & Vision is bundled with the Medical Plans

- » Prescription Drug coverage is provided by Prime Therapeutics.
- » Dental coverage is provided by Delta Dental.
- » Vision coverage is provided by EyeMed.

If you do not elect to enroll at the time of hire, you will not have another opportunity to do so until the next Open Enrollment period unless you experience a qualifying status change.

MDLive—Employees and their dependents have the ability to access medical care via a live connection with a doctor through video chat on their computer or mobile device. Participants in the PPO Plan have a $10 copay. Participants in the HDHP have a $59 cost, which will be applied to the deductible. (Once deductible is met the cost will apply to coinsurance.)

Employee Assistance Program (EAP)—Help with everyday problems whether big or small. The EAP offers confidential help for employees and their family members. Contact the EAP from wherever or whenever it is convenient for you 24 hours a day/7 days a week. Services offered include face-to-face counseling, emotional well-being, legal services, financial services, ID recovery and child and elder care resources.

Flexible Spending Accounts (FSA)—You may participate in the FSA regardless of which medical plan you choose and whether you participate in the Oldcastle BuildingEnvelope Healthcare Plan or not.

- » Healthcare FSA contribution limits $250 to $2,750 for plan year 2022
- » HSA-Compatible FSA for participants in the HSA only (covers dental and vision)
- » Dependent Day Care FSA contribution limits $250 to $5,000 ($2,500 if you are married and filing your taxes separately)
- » For the 2022 plan year, the Healthcare FSA will allow you to automatically carry over up to $550 of any balance remaining at the end of 2022 to be used in 2023. The $550 carryover will not affect the $2,750 limit for contributions in 2023. No need to rush to spend the carryover dollars—there is no deadline in 2023 to spend the amount carried over.
- » The minimum balance required for carryover is $10 for participants who do not enroll in the Health Care Flexible Spending Account for the next plan year.
- » The Dependent Care FSA for daycare has a 2½-month grace period.

If you do not elect to enroll at the time of your hire, you will not have another opportunity to do so until the next Open Enrollment period or you experience a qualifying status change.

Health Savings Account is a tax-advantaged, interest-bearing account. Your money goes in tax free, grows tax free, and can be spent on qualified health expenses tax free. An HSA can be a great way to save for health expenses in both the short- and long-term. **You must be enrolled in the High Deductible Health Plan (HDHP) to participate in the HSA.**

An HSA is similar to a flexible spending account; you contribute pretax dollars to pay for eligible health expenses.

An HSA has several advantages. You never have to forfeit what you don't spend. Your money carries over from year-to-year and even from employer-to-employer. All the while, an HSA can earn tax-free interest in a savings account.

Eligible HSA expenses include deductibles and coinsurance, as well as health expenses that are eligible to be paid with a medical flexible spending account.

Life Insurance—New hires are eligible for up to $300k in coverage without evidence of insurability during the initial enrollment period. Spouses of new hires are eligible for up to $50,000 in coverage without evidence of insurability during the initial enrollment period.

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

Enrollment is available year-round; however, enrollment outside your initial new hire enrollment period is considered a late entrant and is subject to EOI. You may elect a flat amount of $10,000 for dependent children regardless of the number of children and with no EOI.

Disability—All eligible employees will be provided with Short-Term Disability (STD) and Long-Term Disability (LTD) coverage. The premiums for these benefits are paid by Oldcastle BuildingEnvelope. The STD benefit pays 60% of eligible compensation for up to 26 weeks. The LTD plan also pays 60% of eligible compensation and begins after STD has been exhausted.

401(k) Plan—OBE offers a 401(k) plan that allows employees to defer up to 75% of eligible compensation on a pretax basis. We also offer a 5% match that is 100% vested once the employee reaches the eligibility requirements. New employees are subject to automatic enrollment at a 5% deferral rate (effective January 1, 2022) unless they opt out of participation.

Benefit Eligibility

Eligible Employees

Full-time non-union active employees of Oldcastle BuildingEnvelope working and earning income in the U.S. (or union employees eligible to receive these benefits pursuant to a collective bargaining agreement) are eligible to participate in the company's benefit programs. Coverage of these plans terminate the last day of the month in the month of termination.

- A full-time employee must be classified as full-time, regularly scheduled to work an average of 30 hours per week.
- In order to meet the Affordable Care Act's Employer Mandate, Oldcastle BuildingEnvelope will offer health insurance coverage in 2022 to hourly employees who may have been previously ineligible, if they worked an average of 30 hours per week during the 2021 measurement period.
- New hires become eligible on the first of the month following sixty (60) days of continuous employment.
- Spouses/dependents that meet the full-time or new-hire eligibility and who work for Oldcastle BuildingEnvelope may enroll as a participant or be covered as an enrolled dependent (spouse or child) of the other, but not both.

Your Eligible Dependents

- Your legal spouse
- Children up to the end of the month of their 26th birthday, regardless of student status
- Stepchildren up to the end of the month of their 26th birthday, regardless of student status
- Adoption of a child or placement of a child with you for adoption, up to end of the month of their 26th birthday
- Any other children you support for whom you are the legal guardian, up to end of the month of their 26th birthday (must provide copy of the court order)
- Any other children you support as the result of a Qualified Medical Child Support Order or National Medical Support Notice up to the end of the month of their 26th birthday (will be required to provide documentation)
- Dependents totally and permanently disabled before age 19 and subject to verification
- Domestic partners are eligible only if and to the extent required under a work contract between Oldcastle BuildingEnvelope and the federal government or a state, county, city or municipality, and only for the duration of that contract.
- **Common Law Marriage is excluded from coverage under the plan**

Divorce

Once a divorce is finalized, your ex-spouse (and related stepchildren) are no longer eligible dependents. Ineligible dependents cannot stay on the Oldcastle BuildingEnvelope employer-sponsored health plan.

An employer is required to offer COBRA coverage to an ex-spouse, but only if Businessolver is notified within 60 days of the date the divorce is finalized. If you do not give Businessolver proper notice, the ex-spouse will not be offered COBRA coverage.

If an employee is required by a divorce decree or court document to provide health insurance coverage on an ex-spouse, this requires action on the employee's part to provide health insurance coverage — it does not obligate the employer to keep the ex-spouse on the employer-sponsored health plan.

Spousal Surcharge

How to determine if it applies to you

Most companies offer medical coverage to their employees. To manage our costs more efficiently, and to benefit our employees, we encourage working spouses to enroll in their company's plan. If your spouse is eligible for his or her company's medical coverage, and he or she chooses not to enroll and subsequently enrolls in the Oldcastle BuildingEnvelope plan, you will be responsible for paying the spousal surcharge for an additional $200 per month for the PPO plan or $150 per month for the HDHP plan.

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

Qualifications to waive the spousal surcharge

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

If any of the above apply, then the spousal surcharge does not pertain to you and a spousal surcharge waiver must be completed. You must do this online at **www.myOBEbenefits.com** or call the Oldcastle BuildingEnvelope Benefits Helpline at **888.907.1440** during the enrollment process each year to avoid the spousal surcharge deduction.

A qualified status change is the only way a surcharge can be changed and you must go online at **www.myOBEbenefits.com** or call the Oldcastle BuildingEnvelope Benefits Helpline at **888.907.1440** within 60 days of the event. If your spouse enrolls in his or her company's plan and wishes to enroll in Oldcastle BuildingEnvelope' plan as a secondary coverage, the spousal surcharge would apply.

If your spouse gets a job that offers health insurance or becomes eligible through promotion or other means, you must go online at **www.myOBEbenefits.com** or call the Oldcastle BuildingEnvelope Benefits Helpline at **888.907.1440** within 60 days of your spouse's employment date or the date he or she became eligible. If you are paying the spousal surcharge and your spouse quits or is laid off and is no longer employed with insurance, you must go online at **www.myOBEbenefits.com** or call the Oldcastle BuildingEnvelope Benefits Helpline at **888.907.1440** within 60 days of the event in order for the surcharge to be waived and/or to add your spouse to the Oldcastle BuildingEnvelope Healthcare Plan.

Special Enrollment

For employees making mid-year changes to their benefit elections due to qualifying events.

IF YOU EXPERIENCE A QUALIFIED CHANGE IN STATUS, YOU MUST MAKE CHANGES WITHIN 60 DAYS OF THE QUALIFYING EVENT AND PROVIDE THE REQUIRED DOCUMENTATION, OR WAIT TO MAKE THESE CHANGES DURING THE NEXT ENROLLMENT PERIOD.

Changing or Dropping Coverage

How to keep your plan current with life's changes

Oldcastle BuildingEnvelope gives you an opportunity to change your benefit choices during Annual Open Enrollment each year. Because many of the benefits we offer are paid with pretax deductions, the IRS restricts changes to benefit elections and coverage during the calendar year. You may only make a change to your coverage elections in your healthcare and flexible spending accounts (FSAs), if you have a change in your family status.

Family status changes typically include

- Marriage
- Divorce
- Birth or adoption of a child
- Death of a spouse or eligible dependent
- Loss of coverage because your spouse's employment changed (decrease in hours to part-time status or job loss, for instance)
- Military leave
- Qualifying Disability

Consistency Requirements

Any requested benefit change must be consistent with your family status changes.

- The family status change must result in you, your spouse or your dependent child gaining or losing eligibility for coverage under one of the Oldcastle BuildingEnvelope plans or another employer's health plan.
- Your requested benefit change also must be consistent with that gain or loss of eligibility. If you are gaining eligibility for another employer's plan you must actually elect that coverage.
- If a qualified medical child support order requires that your child be covered under a plan, you may change your benefit choice to provide coverage for the child. Likewise, if your former spouse is required under a qualified medical child support order to provide coverage for a child you cover under the Oldcastle BuildingEnvelope plan, you may drop coverage under this plan for that child.
- If you, your spouse or your dependent child becomes entitled to Medicare or Medicaid, you may drop medical coverage for the person entitled to Medicare or Medicaid.
- If you, your spouse or dependent child becomes entitled to a special enrollment opportunity as defined by the Health Insurance Portability and Accountability Act (HIPAA), you may change your medical election to correspond with the special enrollment rights of that individual.

Note: Addition of dependents will be subject to Dependent Verification requirements.

Divorce

Once a divorce is finalized, your ex-spouse, and related stepchildren are no longer eligible dependents. Ineligible dependents cannot stay on the Oldcastle BuildingEnvelope employer-sponsored health plan.

An employer is required to offer COBRA coverage to an ex-spouse, but only if Businessolver is notified within 60 days of the date the divorce is finalized. If you do not give Businessolver proper notice, the ex-spouse will not be offered COBRA coverage.

If an employee is required by a divorce decree or court document to provide health insurance coverage on an ex-spouse, this requires action on the employee's part to provide health insurance coverage – it does not obligate the employer to keep the ex-spouse on the employer-sponsored health plan.

Consider Your Options Carefully...

If you wish to make a change in your benefit elections after the enrollment period has ended, you will not be allowed to do so unless you experience a qualified change in status such as marriage, divorce, birth of a child, death, change in job status, military leave or disability. If you experience a qualified change in status, you must make changes within 60 days of the qualifying event and provide the required documentation, or wait to make these changes during the next enrollment period.

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

Qualifying Status Changes

Family status changes that can trigger change opportunity with the required verification of changes.

Qualifying event	Required proof items	Send by this date	Permitted change(s) within 60 days of the Qualifying Event	Changes not permitted
Your marriage	Copy of the marriage certificate	Within 60 days of marriage	• Enroll yourself, if applicable • Enroll your new spouse and other newly eligible dependents	• Drop health coverage and not enroll in spouse's plan
Your divorce, annulment, or legal separation	Copy of the court order granting divorce or annulment	Within 60 days of the date of final divorce decree or annulment	• Drop your spouse from your health coverage • In the event of divorce, the employee's children do not lose eligibility, but the employee's stepchildren would lose eligibility. • Enroll yourself and dependent children if you or they were previously enrolled in your spouse's plan	• Drop health coverage for yourself or any other covered individuals
Birth of your child	Copy of birth certificate	Within 60 days of birth	• Enroll yourself or your spouse, if applicable • Enroll the eligible child	• Drop health coverage for yourself and not enroll in spouse's plan
Your adoption of a child	Copy of the court order approving the final adoption	Within 60 days of adoption	• Enroll yourself or your spouse, if applicable • Enroll the eligible child named	• Drop health coverage for yourself and not enroll in spouse's plan
Placement of a child with you for adoption	Copy of the court order approving the placement for adoption	Within 60 days of placement for adoption	• Enroll yourself or your spouse, if applicable • Enroll the eligible child named	• Drop health coverage for yourself and not enroll in spouse's plan
Loss of child's eligibility (i.e., child reaches the maximum age 26 for coverage)	Notification provided by carrier	Notify within 60 days of loss of eligibility	• Drop the child who lost eligibility from your health coverage	• Change health plans • Drop health coverage for yourself or any other covered individuals
Death of your spouse or dependent child	Copy of the death certificate	Within 60 days of spouse's or dependent's death	• Drop the dependent from your health coverage	• Change health plans • Drop health coverage for yourself or any other covered individuals
A change in employment status classification from non-union to union or union to non-union	Copy of employer communication reflecting change in classification	Within 60 days of change in employment status classification	• Enroll yourself, if applicable • Enroll your spouse and other eligible dependents • Drop health coverage • Drop your spouse and other eligible dependents from your health coverage	• Enroll, drop or change plans if your employment change does not result in your being eligible for a new set of benefits
A change in employment status classification from Full-Time to Part-Time (See "When Coverage Ends" in Appendix A for additional information)	Copy of employer communication reflecting change in health coverage	Within 60 days of effective date of change in coverage	• Drop health coverage • Drop your spouse and other eligible dependents from your health coverage	• Enroll yourself, spouse and other eligible dependents
A change in employment status classification from Part-Time to Full-Time	Copy of employer communication reflecting change in classification	Within 60 days of change in employment status classification	• Enroll yourself, if applicable • Enroll your spouse and other eligible dependents	• Enroll, drop or change plans if your employment change does not result in your being eligible for a new set of benefits

Qualifying event	Required proof items	Send by this date	Permitted change(s) within 60 days of the Qualifying Event	Changes not permitted
A change in the place of residence or worksite of you, your spouse or your dependent child, if the move affects your eligibility (ex: employee moves out of an HMO's service area)	Written notification with new address and effective date of change in residence	Within 60 days after change of place of residence or worksite	• Enroll yourself, if applicable • Enroll your spouse and other eligible dependents • Drop health coverage • Drop your spouse and other eligible dependents from your health coverage	• Change health plans • Enroll, drop or change plans if the change does not affect your eligibility
Significant change in or cost of your or your spouse's health coverage due to spouse's employment including open enrollment	Copy of employer communication reflecting change in or cost of health coverage	Within 60 days of effective date of change in coverage	• Enroll yourself, if applicable • Enroll your spouse and other eligible dependents	• Change health plans
Spouse's loss of coverage	Letter from employer verifying loss of coverage or COBRA election notice	Within 60 days of the date of loss of coverage	• Enroll your spouse and, if applicable, eligible dependent children in your health plan • Enroll yourself in a health plan if previously not enrolled because you were covered under your spouse's plan	• Change health plans • Drop health coverage for yourself or any other covered dependents
You or your spouse taking a qualified leave of absence (unpaid)	Copy of leave of absence request form or approval	Within 60 days of the date leave begins	• Enroll yourself, if applicable • Enroll your spouse and other eligible dependents • Drop health coverage • Drop your spouse and other eligible dependents from your health coverage	• Change health plans • Enroll, drop or change plans if the change does not affect your eligibility
Eligibility for Government-sponsored plan, such as Medicare (excluding the Government-sponsored Marketplace)	Copy of eligibility confirmation document	Within 60 days of eligibility date	• Drop coverage for the person who became entitled to Medicare, Medicaid or other eligible coverage	• Change health plans • Drop health coverage for yourself or any other covered individuals who are not newly eligible for Medicare, Medicaid, or other eligible coverage
CHIP Special Enrollment— loss of eligibility for coverage under a State Medicaid or CHIP program, or eligibility for State premium assistance under Medicaid or CHIP	Copy of loss of eligibility document or premium assistance notification	Within 60 days of loss of eligibility or eligibility date	• Enroll yourself, if applicable • Add the person who lost entitlement to CHIP • Drop coverage for the Person entitled to CHIP coverage	• Drop health coverage for yourself or any other covered individuals who are not newly eligible for CHIP coverage
Qualified Medical Child Support Order affecting a dependent child's coverage	Copy of original court order requiring coverage	Within 60 days of order	• Enroll yourself, if applicable • Enroll the eligible child named on QMCSO	• Make any other changes, except as required by the QMCSO

Qualifying event	Required proof items	Send by this date	Permitted change(s) within 60 days of the Qualifying Event	Changes not permitted
You become the legal guardian of a dependent child	Copy of original court documents awarding legal guardianship	Within 60 days of the date you become the legal guardian	• Enroll yourself, if applicable • Enroll the eligible child	• Drop health coverage for yourself or any other covered individuals who are not newly eligible

Changes in Elections

It is your responsibility to notify Oldcastle BuildingEnvelope of any family status change as soon as possible and within the specified number of days. If notification is not made within the specified number of days, you will not be allowed to make a benefit change until the next Annual Enrollment due to IRS rules. You must go online at **www.myOBEbenefits.com** or call the Oldcastle BuildingEnvelope Benefits Helpline at **888.907.1440** to make the change and provide the required documentation with proof of the event.

Rehired Employees

» If the break in service is 30 days or less; coverage will be reinstated with the same elections and no lapse in coverage as if they had never terminated employment.

» If the break in service is 31 days to 180 days; employee is eligible for coverage effective 1st of day of the month following date of rehire. Employee must make an active election to gain coverage.

» If break in service is more than 180 days; New hire eligibility will apply and coverage would be effective 1st day of the month following sixty (60) days of employment. Employee must make an active election to gain coverage.

» If initial eligibility was not met and there is a break in service, the time from the initial hire date will count towards eligibility.

Medical Plans

Be sure you're in the plan that makes the most sense for the care you need.

You have two Medical/Rx Plan options:

» **PPO Plan** (see pages 16 and 17 for a summary of benefits) this is a Preferred Provider Plan that offers a lower deductible and copays for doctor visits.

» **HDHP Plan** (see pages 18 and 19 for a summary of benefits) this is a High Deductible Plan that offers lower premium contributions, higher deductibles, and no copays, along with the Health Savings Account (HSA). The HSA includes an employer contribution and an option for pretax employee contributions.

MyChoice helps you make the Right Choice

Businessolver's MyChoice Plan Comparison Tool recommendation engine is built on the belief that people don't want to shop for benefits. Sometimes too much choice is too much choice. Employees need to consider more than just cost to make meaningful decisions. By identifying not only financial and physical needs of each employee, MyChoice Plan Comparison Tool is able to address the emotional side of the benefit selection process. This unique philosophy creates a personalized strategy for employees that can help drive decision-making. MyChoice Plan Comparison Tool is accessible on **www.myOBEbenefits.com**.

The outcome from this tool is based on the national average cost of medical service and prescription prices and may vary depending on your specific treatment options. It is just meant to provide basic information about the plan differences.

Remember that each plan:

» Includes Dental and Vision

» Offers you the flexibility of choosing in-network or out-of-network providers for care

  » In-network providers offer the lowest cost for both you and the Company. Visit BCBSTX at **www.bcbstx.com** for a list of providers.

  » Out-of-network providers may attempt to collect the full amount of charges by billing the member for the difference between how much the Plan reimbursed and the provider's total charge. This is typically referred to as balance billing.

All plans provide 100% coverage for annual in-network preventive care benefits for all members. This wellness benefit is used for preventive care expenses such as:

» Annual physicals

» Immunizations and vaccines

» Well-baby care, including immunizations

» Well-woman care, including mammograms and osteoporosis screenings

» Colorectal and prostate screenings

» Screenings for high blood pressure, diabetes, cholesterol

» Breastfeeding support

Use Your Preventive Care Benefit—It Could Save Your Life!

» Regular mammograms reduce the risk of breast cancer through early detection.

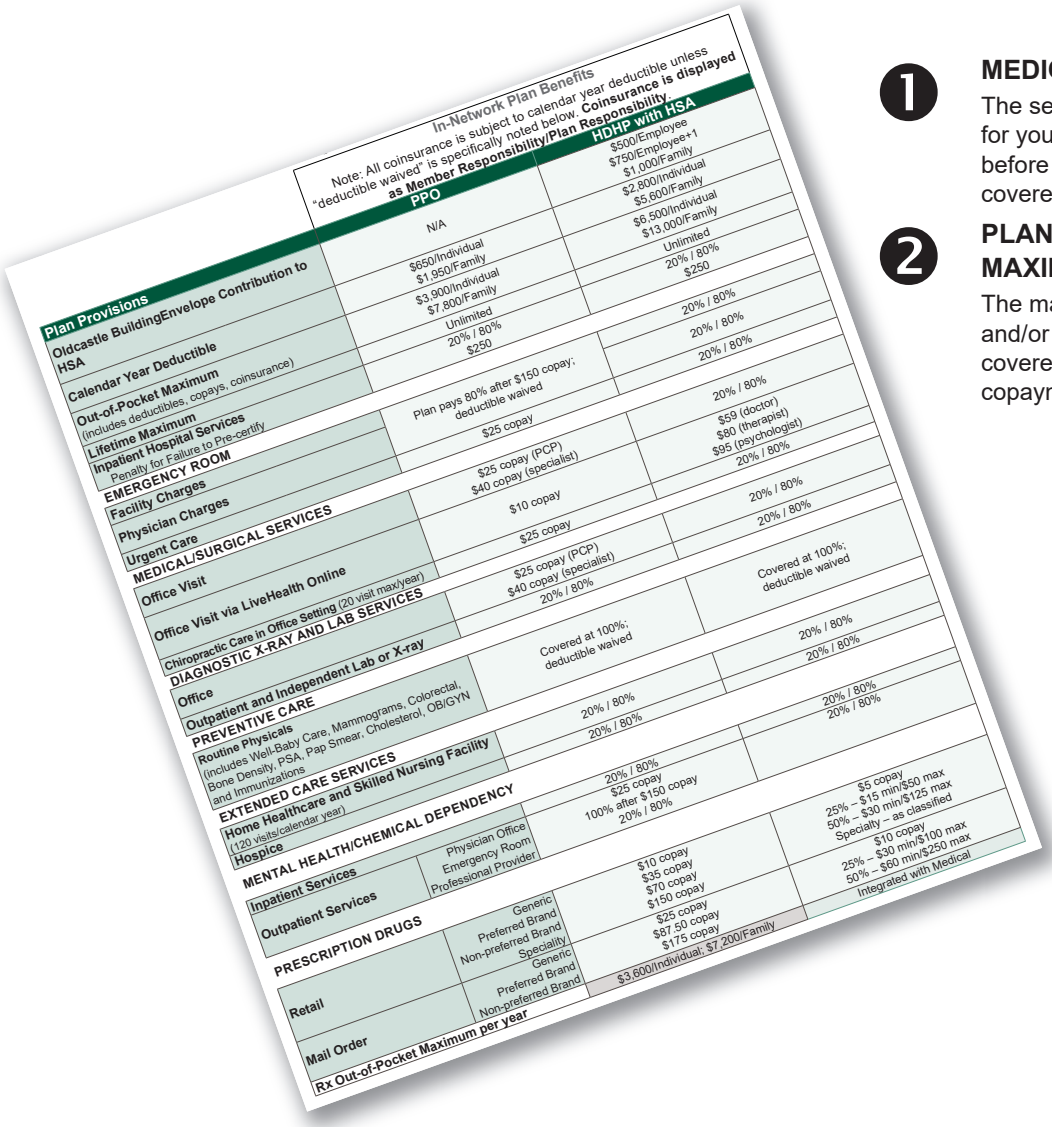
» Routine colorectal screens reduce colorectal cancer through early detection.

» Nearly 70% of those who have high blood pressure do not have it under control. Lowering blood pressure levels reduces the risk of heart disease and stroke.

For details on each plan, see the Oldcastle BuildingEnvelope Healthcare Plan Summary on pages 16 through 19

For coverage restrictions and limitations, refer to your Summary Plan Description, available through your HR/Benefits Department and online at www.myOBEbenefits.com

Understanding Your Benefits Summary



In-Network Plan Benefits

Note: All coinsurance is subject to calendar year deductible unless "deductible waived" is specifically noted below. **Coinsurance is displayed as Member Responsibility/Plan Responsibility.**

Plan Provisions	PPO	HDHP with HSA
Oldcastle BuildingEnvelope Contribution to HSA	N/A	$500/Employee $750/Employee+1
Calendar Year Deductible	$650/Individual $1,950/Family	$1,000/Family $2,800/Individual
Out-of-Pocket Maximum (includes deductibles, copays, coinsurance)	$3,900/Individual $7,800/Family	$5,600/Family $6,500/Individual
Lifetime Maximum	Unlimited	$13,000/Family Unlimited
Inpatient Hospital Services Penalty for Failure to Pre-certify	20% / 60% $250	20% / 80% $250
EMERGENCY ROOM	Plan pays 80% after $150 copay; deductible waived	20% / 80%
Facility Charges	$25 copay	20% / 80%
Physician Charges		20% / 80%
Urgent Care	$25 copay (PCP) $40 copay (specialist)	$59 (doctor) $80 (therapist) $95 (psychologist)
MEDICAL/SURGICAL SERVICES	$10 copay	20% / 80%
Office Visit	$25 copay	20% / 80%
Office Visit via LiveHealth Online	$25 copay (PCP) $40 copay (specialist)	20% / 80%
Chiropractic Care in Office Setting (20 visit max/year)	20% / 80%	Covered at 100%; deductible waived
DIAGNOSTIC X-RAY AND LAB SERVICES	Covered at 100%; deductible waived	20% / 80%
Outpatient and Independent Lab or X-ray		20% / 80%
Office	20% / 80%	20% / 80%
PREVENTIVE CARE	20% / 80%	20% / 80%
Routine Physicals (includes Well-Baby Care, Mammograms, Colorectal, Bone Density, PSA, Pap Smear, Cholesterol, OB/GYN and Immunizations	20% / 80%	20% / 80%
EXTENDED CARE SERVICES	20% / 80%	20% / 80%
Home Healthcare and Skilled Nursing Facility (120 visits/calendar year)	$25 copay 100% after $150 copay 20% / 80%	$5 copay 25% – $15 min/$50 max 50% – $30 min/$125 max Specialty – as classified
Hospice		$10 copay 25% – $30 min/$100 max 50% – $60 min/$250 max
MENTAL HEALTH/CHEMICAL DEPENDENCY		Integrated with Medical
Inpatient Services	Physician Office Emergency Room Professional Provider	
Outpatient Services		
PRESCRIPTION DRUGS		
Retail	Generic Preferred Brand Non-preferred Brand Specialty	$10 copay $35 copay $70 copay $150 copay
Mail Order	Generic Preferred Brand Non-preferred Brand	$25 copay $87.50 copay $175 copay
Rx Out-of-Pocket Maximum per year		$3,600/Individual; $7,200/Family

1 **MEDICAL DEDUCTIBLE**

The set dollar amount that you must pay for yourself and/or your family members before the insurance begins to pay for covered medical benefits.

2 **PLAN YEAR OUT-OF-POCKET MAXIMUM**

The maximum dollar amount that you and/or your family pays each year for covered medical services in the form of copayments and coinsurance.

3 **COPAY**

A specific amount you pay directly to a provider when you receive covered services This can be either a fixed dollar amount or a percentage of the In-Network Rate.

4 **IN-NETWORK**

In-network benefits apply when you receive covered services from in-network providers You are responsible to pay the applicable copayment.

5 **OUT-OF-NETWORK**

If your plan allows the use of out-of-network providers, out-of-network benefits apply when you receive covered services You are responsible to pay the applicable copay, plus the difference between the billed amount and In-Network Rate.

6 **IN-NETWORK RATE**

The amount in-network providers have agreed to accept as payment in full If you use an out-of-network provider, you will be responsible to pay your portion of the costs as well as the difference between what the provider bills and the In-Network Rate (balance billing). In this case, the allowed amount is based on our in-network rates for the same service.

Glossary of Common Medical Terms

Allowed Amount

Maximum amount on which payment is based for covered healthcare services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal

A request for your health insurer or plan to review a decision.

Balance Billing

When a provider bills you for the difference between the provider’s charges and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Coinsurance

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

Copayment

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

Deductible

The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $650, your plan won’t pay anything until you’ve met your $650 deductible for covered healthcare services subject to the deductible. The deductible may not apply to all services.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would see care right away to avoid severe harm.

Formulary

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

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn’t require an overnight stay.

Network

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

Out-of-Pocket Limit

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

Physician Services

Healthcare services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Primary Care Physician

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

Urgent Care

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

BCBSTX Pre-certification Process

Pre-certification Requirement

Pre-certification is completed using nationally-recognized standards and guidelines while considering your individual clinical status. Our Registered Nurses and physicians will review your physician's request for services for medical necessity and appropriateness of the recommended care. We realize that there is a person behind every request and that your time is important; that is why we are committed to timely turnaround times when you are accessing care. With every request processed, we have the opportunity to ensure you are receiving quality, medically appropriate care.

Determine if Your Care Requires Pre-certification

Before you can schedule certain healthcare services you may need to get pre-approval from BCBSTX. This is called pre-certification. Your provider should contact BCBSTX for pre-certification and may be asked for details such as your diagnosis, why you need the service, and where you are getting the service before the procedure is approved. By pre-certifying a service, treatment plan, or procedure, BCBSTX is agreeing that the healthcare recommended is medically necessary.

It's important to discuss pre-certification of any procedure with your provider prior to your service.

Pre-certification is not a guarantee of benefits. Non-medically necessary procedures rendered without pre-certification may result in denial of benefits. Members will incur a $250 penalty for any inpatient hospital service that is not pre-certified prior to the service for Out-of-Network situations.

Call BCBSTX at 800.441.9188 to determine if your planned medical services require pre-certification.

The following services must be pre-certified:

1. Inpatient Medical/Surgical Facility Admissions Including Transfers:
   - Acute Care / Hospital
   - Coordinated Home Care / Transitional Care
   - Hospice Care
   - Long Term Acute Care / Sub-acute
   - Rehabilitation Facility
   - Skilled Nursing Facility
2. Outpatient Medical/Surgical Services:

   Through AIM
   - Advanced Imaging / Radiology
   - Cardiology
   - Molecular Genetic Lab Testing
   - Musculoskeletal - Joint, Spine Surgery
   - Musculoskeletal – Pain
   - Radiation Therapy / Radiation Oncology
   - Sleep

   Through BCBSTX
   - Cardiology – Lipid Apheresis
   - Chiropractic Services
   - Ear, Nose and Throat
   - Gastroenterology
   - Hyperbaric Treatment
   - Neurology
   - Occupational Therapy / Physical Therapy / Speech Therapy
   - Oral and Dental Procedures and Surgery
   - Orthopedic Musculoskeletal
   - Outpatient Surgery (Breast, Deactivation of Headache Triggers, Jaw, Obesity)
   - Pain Management
   - Wound Care
3. Other services:
   - Dialysis obtained from an Out-of-Network-Provider
   - Durable Medical Equipment
   - Home Health Services including but not limited to home private duty nursing (PDN) and home infusion therapy (HIT)
   - Home Hemodialysis
   - Home Hospice
   - Home Infusion Therapy (HIT)
   - Non-Emergent Air Ambulance
   - Out-of-Network/Out-of-Plan Services – Outpatient elective surgery received in an out-of-network Hospital or ambulatory surgical center
   - Transplant Evaluations and Transplants
4. Behavioral Health and Chemical Dependency Facility Admissions:
   - Inpatient
   - Partial Hospitalization
   - Residential Treatment Center (RTC)
5. Behavioral Health and Chemical Dependency Services Outpatient:
   - Applied Behavioral Analysis (ABA)
   - Electroconvulsive Therapy
   - Intensive Outpatient Treatment
   - Psychological Testing/Neuropsychological Testing
   - Repetitive Transcranial Magnetic Stimulation

Services the Oldcastle BuildingEnvelope Medical Plan does NOT Cover

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

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

BlueCross BlueShield of Texas

www.bcbstx.com
800.521.2227 Customer Service
800.441.9188 Pre-authorization

Medical Plans Comparison for 2022

		In-Network Plan Benefits Note: All coinsurance is subject to calendar year deductible unless "deductible waived" is specifically noted below. **Coinsurance is displayed as Member Responsibility/Plan Responsibility**.	
Plan Provisions		**PPO**	**HDHP with HSA**
Oldcastle BuildingEnvelope Contribution to HSA		N/A	$500/Employee $750/Employee+1 $1,000/Family
Calendar Year Deductible		$650/Individual $1,950/Family	$2,800/Individual $5,600/Family
Out-of-Pocket Maximum (includes deductibles, copays, coinsurance)		$3,900/Individual $7,800/Family	$6,500/Individual $13,000/Family
Lifetime Maximum		Unlimited	Unlimited
Inpatient Hospital Services Penalty for Failure to Pre-certify		20% / 80% $250	20% / 80% $250
EMERGENCY ROOM			
Facility Charges		Plan pays 80% after $150 copay; deductible waived	20% / 80%
Physician Charges			20% / 80%
Urgent Care		$25 copay	20% / 80%
MEDICAL/SURGICAL SERVICES			
Office Visit		$25 copay (PCP) $40 copay (specialist)	20% / 80%
Office Visit via MDLive		$10 copay	20% / 80%
Chiropractic Care in Office Setting (20 visit max/year)		$25 copay	20% / 80%
DIAGNOSTIC X-RAY AND LAB SERVICES			
Office		$25 copay (PCP) $40 copay (specialist)	20% / 80%
Outpatient and Independent Lab or X-ray		20% / 80%	20% / 80%
PREVENTIVE CARE			
Routine Physicals (includes Well-Baby Care, Mammograms, Colorectal, Bone Density, PSA, Pap Smear, Cholesterol, OB/GYN and Immunizations		Covered at 100%; deductible waived	Covered at 100%; deductible waived
EXTENDED CARE SERVICES			
Home Healthcare and Skilled Nursing Facility (120 visits/calendar year)		20% / 80%	20% / 80%
Hospice		20% / 80%	20% / 80%
MENTAL HEALTH/CHEMICAL DEPENDENCY			
Inpatient Services		20% / 80%	20% / 80%
Outpatient Services	Physician Office Emergency Room Professional Provider	$25 copay 100% after $150 copay 20% / 80%	20% / 80%
PRESCRIPTION DRUGS			
Retail	Generic Preferred Brand Non-preferred Brand Speciality	$10 copay $35 copay $70 copay $150 copay	$5 copay 25% – $15 min/$50 max 50% – $30 min/$125 max Specialty – as classified
Mail Order	Generic Preferred Brand Non-preferred Brand	$25 copay $87.50 copay $175 copay	$10 copay 25% – $30 min/$100 max 50% – $60 min/$250 max
Rx Out-of-Pocket Maximum per year		$3,600/Individual; $7,200/Family	Integrated with Medical

Oldcastle BuildingEnvelope PPO 2022 Benefit Summary

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

Plan Provisions	PPO In-Network	PPO Out-of-Network
Calendar Year Deductible*	$650 Individual/$1,950 Family	$1,300 Individual/$3,900 Family
Out-of-Pocket Maximum – per calendar year (includes the deductible, copays and coinsurance)	$3,900 Individual/$7,800 Family (per calendar year)	Unlimited
Lifetime Maximum per Participant	Unlimited	
Inpatient Hospital Services Penalty for Failure to Pre-certify	20% / 80% $250	40% / 60% $250
EMERGENCY ROOM/TREATMENT ROOM (Accident and Medical Emergency Situation within 48 hours)		
Facility Charges	Plan pays 80% after $150 member copay; deductible waived	
Physician Charges		
Urgent Care	$25 copay	
NON-EMERGENCY SITUATIONS		
Facility Charges	20% / 80%	40% / 60%
Physician Charges	20% / 80%	40% / 60%
MEDICAL-SURGICAL SERVICES		
Office Visit	$25 PCP copay; $40 specialist copay	40% / 60%
Online Visit through MDLive	$10 copay/doctor, therapist or psychologist	N/A
Physician Surgical Services Inpatient	20% / 80%	40% / 60%
Physician Surgical Services Outpatient	20% / 80%	40% / 60%
Facility Surgical Services Outpatient	20% / 80%	40% / 60%
Home Infusion Therapy	20% / 80%	40% / 60%
In-Vitro Fertilization	Not Covered	
Chiropractic Care in an Office Setting 20 visits per calendar year (combined in/out-of-network)	$25 copay	40% / 60%
Physical, Occupational, and Speech Therapy 30 visits each per calendar year (combined in/out-of-network)	$25 copay	40% / 60%
DIAGNOSTIC X-RAY AND LABORATORY SERVICES		
Office	$25 PCP copay; $40 specialist copay	40% / 60%
Outpatient	20% / 80%	40% / 60%
Independent Lab or X-ray	20% / 80%	40% / 60%
PREVENTIVE CARE		
Routine Physicals/Well Baby Care/ Mammograms/Colorectal/Bone Density/PSA/ Pap Smear/Cholesterol	0% / 100%*	Not Covered
OB/GYN and Immunizations	0% / 100%*	40% / 60%
EXTENDED CARE SERVICES		

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

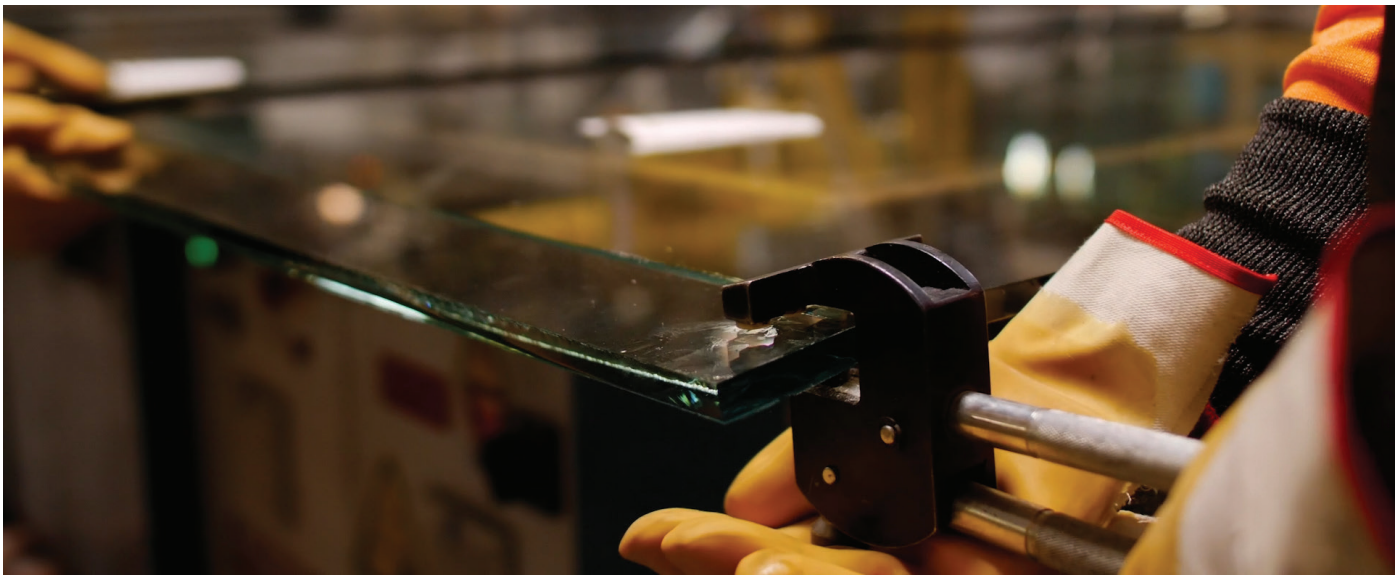
For example, if you, your spouse, and child are on a *family* plan with a $1,950 *family* embedded *deductible,* and the *individual deductible* is $650, and your child *incurs* $650 in medical bills, his/her deductible is met, and your *Plan* will help pay subsequent medical bills for that child during the remainder of the *calendar year,* even though the *family deductible* of $1,950 has not been met yet.

Oldcastle BuildingEnvelope PPO 2022 Benefit Summary (cont.)

Plan Provisions	PPO In-Network	PPO Out-of-Network
Home Healthcare 120 Visits Per Calendar Year	20% / 80%	40% / 60%
Skilled Nursing Facility 120 Days Maximum Per Calendar Year	20% / 80%	40% / 60%
Hospice Care Benefits used In-Network or Out-of-Network apply towards satisfying both maximums.	20% / 80%	40% / 60%
MENTAL HEALTH (MH)/CHEMICAL DEPENDENCY		
Inpatient Services		
Hospital Services (Facility)	20% / 80%	40% / 60%
Physician Services	20% / 80%	40% / 60%
Outpatient Services		
Services Performed in Physician Office (Non-Surgical)	$25 copay	40% / 60%
Emergency Room/Treatment Room/Facility Charges	100% after $150 copay	100% after $150 copay
Professional Provider	20% / 80%	40% / 60%

PRESCRIPTION DRUGS	
Rx Out-of-Pocket Maximum per Calendar Year	$3,600 Individual / $7,200 Family per calendar year
Retail	
Generic	$10 copay
Preferred Brand	$35 copay
Non-Preferred Brand	$70 copay
Specialty	$150 copay
Mail-Order/90-Day Retail	
Generic	$25 copay
Preferred Brand	$87.50 copay
Non-Preferred Brand	$175 copay

*Deductible waived



Oldcastle BuildingEnvelope HDHP 2022 Benefit Summary

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

Plan Provisions	HDHP In-Network	HDHP Out-of-Network
Calendar Year Deductible*	$2,800 Individual/$5,600 Family	$5,600 Individual/$11,200 Family
Out-of-Pocket Maximum – Per Calendar Year (includes the deductible, copays and coinsurance)	$6,500 Individual/$13,000 Family	Unlimited
Oldcastle BuildingEnvelope HSA Contribution	Employee: $500 | Employee +1: $750 Employee + 2 or more: $1,000 | Family: $1,000	
Lifetime Maximum per Participant	Unlimited	
Inpatient Hospital Services Penalty for Failure to Pre-certify	20% / 80% $250	40% / 60% $250
EMERGENCY ROOM/TREATMENT ROOM (Accident & Medical Emergency Situation within 48 hours)		
Facility Charges	20% / 80%	
Physician Charges	20% / 80%	
Urgent Care	20% / 80%	
NON-EMERGENCY SITUATIONS		
Facility Charges	20% / 80%	40% / 60%
Physician Charges	20% / 80%	40% / 60%
MEDICAL-SURGICAL SERVICES		
Office Visit	20% / 80%	40% / 60%
Online Visit through MDLive	Deductible / Coinsurance	N/A
Physician Surgical Services Inpatient	20% / 80%	40% / 60%
Physician Surgical Services Outpatient	20% / 80%	40% / 60%
Facility Surgical Services Outpatient	20% / 80%	40% / 60%
Home Infusion Therapy	20% / 80%	40% / 60%
In-Vitro Fertilization	Not Covered	
Chiropractic Care in an Office Setting 20 visits per calendar year (combined in/out-of-network)	20% / 80%	40% / 60%
Physical, Occupational, and Speech Therapy 30 visits each per calendar year (combined in/out-of-network)	20% / 80%	40% / 60%
DIAGNOSTIC X-RAY AND LABORATORY SERVICES		
Outpatient	20% / 80%	40% / 60%
Independent Lab or X-ray	20% / 80%	40% / 60%
PREVENTIVE CARE		
Routine Physicals/Well Baby Care/ Mammograms/Colorectal/Bone Density/PSA/Pap Smear/Cholesterol	0% / 100%*	Not Covered
OB/GYN and Immunizations	0% / 100%*	40% / 60%
EXTENDED CARE SERVICES		
Home Healthcare 120 Visits Per Calendar Year	20% / 80%	40% / 60%

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

For example, if you, your spouse, and child are on a *family* plan with a $5,600 *family* embedded *deductible,* and the *individual deductible* is $2,800, and your child *incurs* $2,800 in medical bills, his/her *deductible* is met, and your *Plan* will help pay subsequent medical bills for that child during the remainder of the *calendar year,* even though the *family deductible* of $5,600 has not been met yet.

Oldcastle BuildingEnvelope HDHP 2022 Benefit Summary (cont.)

Plan Provisions	HDHP In-Network	HDHP Out-of-Network
Skilled Nursing Facility 120 Days Maximum Per Calendar Year	20% / 80%	40% / 60%
Hospice Care Benefits used in Network or Out-of-Network apply towards satisfying both maximums.	20% / 80%	40% / 60%
MENTAL HEALTH (MH)/CHEMICAL DEPENDENCY		
Inpatient Services		
Hospital Services (Facility)	20% / 80%	40% / 60%
Physician Services	20% / 80%	40% / 60%
Outpatient Services		
Services Performed in Physician Office (Non-Surgical)	20% / 80%	40% / 60%
Emergency Room/Treatment Room/Facility Charges	20% / 80%	40% / 60%
Professional Provider	20% / 80%	40% / 60%

PRESCRIPTION DRUGS

The prescription plan for the HDHP plan is integrated with the medical plan, which means the deductible for the medical plan must be met before the coinsurance/copay applies for **any drugs covered by** the prescription plan.

Retail	Minimum	Member % Coinsurance	Maximum
Generic	$5	N/A	$5
Preferred Brand	$15	25%	$50
Non-Preferred Brand	$30	50%	$125
Mail-Order/90-Day Retail			
Generic	$10	N/A	$10
Preferred Brand	$30	25%	$100
Non-Preferred Brand	$60	50%	$250

*Deductible waived

2022 Employee Contributions

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

All contributions include medical, prescription, dental and vision benefits

	Employee Contributions						Monthly Spousal Surcharge
Employee Tier	**PPO Plan Standard Rate**		**PPO Plan With Wellness Credit EE Only**		**PPO Plan With Wellness Credit EE and Spouse**		**PPO Plan**
	Annual Rate	**Monthly Rate**	**Annual Rate**	**Monthly Rate**	**Annual Rate**	**Monthly Rate**	**Monthly Spousal Surcharge**
Employee Only	$1,824	$152	$1,524	$127			
Employee + Spouse	$3,732	$311	$3,432	$286	$3,132	$261	$200
Employee + Child(ren)	$3,264	$272	$2,964	$247			
Family	$5,208	$434	$4,908	$409	$4,608	$384	$200
Employee Tier	**HDHP Plan Standard Rate**		**HDHP Plan With Wellness Credit EE Only**		**HDHP Plan With Wellness Credit EE and Spouse**		**HDHP w/HSA Plan**
	Annual Rate	**Monthly Rate**	**Annual Rate**	**Monthly Rate**	**Annual Rate**	**Monthly Rate**	**Monthly Spousal Surcharge**
Employee Only	$1,104	$92	$804	$67			
Employee + Spouse	$2,158	$179	$1,848	$154	$1,548	$129	$150
Employee + Child(ren)	$1,896	$158	$1,596	$133			
Family	$2,856	$238	$2,556	$213	$2,256	$188	$150

NOTE: The premium rates listed above are annual and monthly rates. Your payroll deductions may vary based on your company-specific payroll frequency.

Wellness Credit

The Wellness credit for a premium reduction in 2022 applies only to employees and their covered spouses who completed the required wellness visit between September 1, 2020 and August 31, 2021.

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

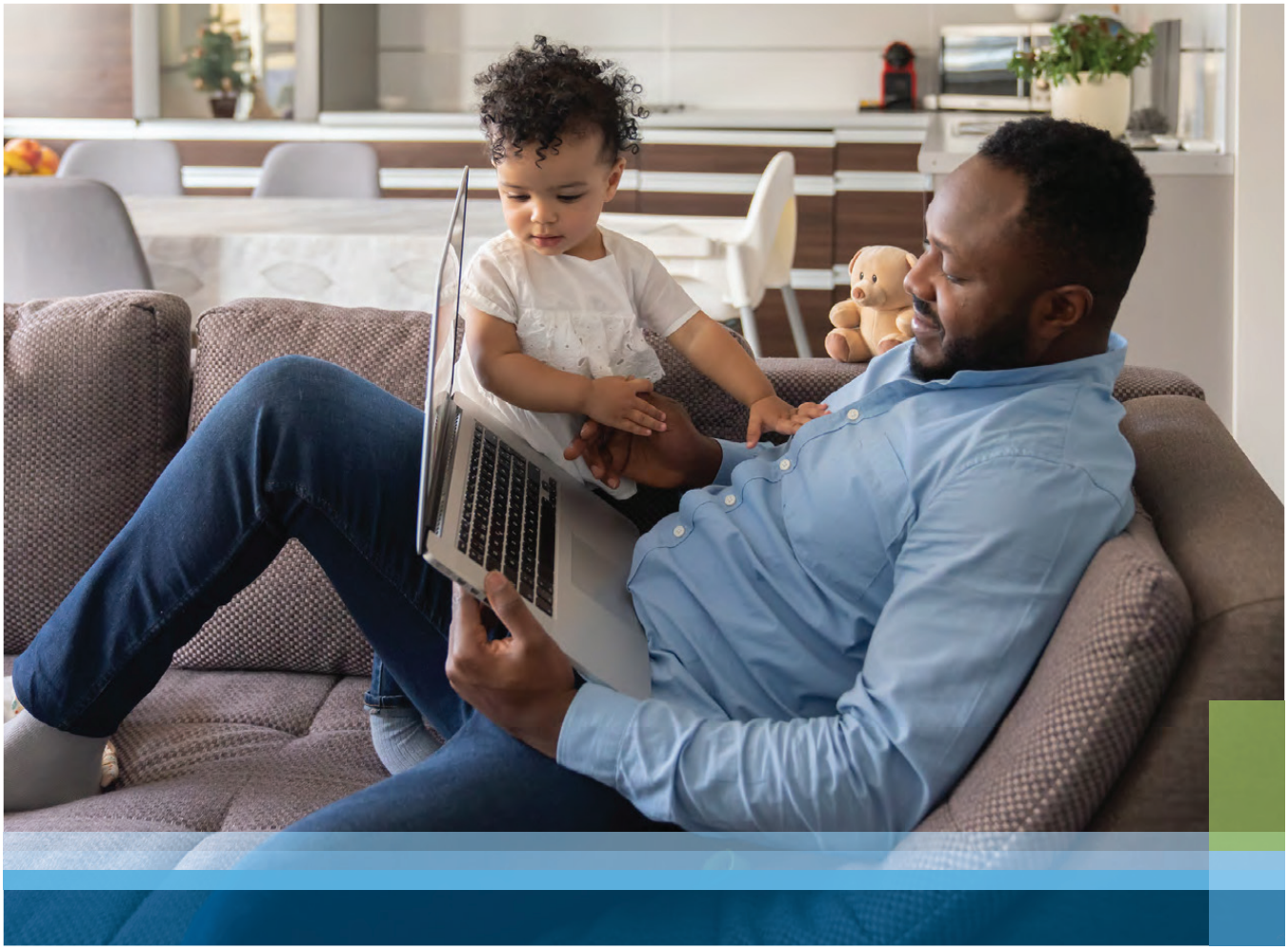
If both the employee and their covered spouse completed the wellness initiative, the credit is $50 per month. The employee was required to complete the initiative in order for the spouse to receive credit.

Please be on the lookout for additional information in regards to the 2023 Wellness Credit.

Deductions

Did you know your deductions for your healthcare premiums are made on a pretax basis? Because your deductions are taken before taxes, you reduce your taxable income and save on federal, social security and most state income taxes. However, because these premiums are collected on a pretax basis the IRS restricts enrollment changes to annual open enrollment or within 60 days of a qualified life event.

BlueCross BlueShield of Texas



Virtual Visits: Get 24/7 Care, Anywhere

Call your doctor's office first. They also may offer telehealth consultations by phone or online video.

With Virtual Visits, the doctor is always in. Get 24/7 non-emergency care from a board-certified doctor by phone, online video or mobile app from the privacy and comfort of your own home.

Don't risk crowded waiting rooms, expensive urgent care or ER bills, or waiting weeks or more to see a doctor, when you can speak with a Virtual Visits doctor within minutes.

Powered by MDLIVE

Virtual Visits, provided by Blue Cross and Blue Shield of Texas (BCBSTX) and powered by MDLIVE®, are a convenient alternative for treatment of more than 80 health conditions, including:

- Allergies
- Cold/Flu
- Fever
- Headaches
- Nausea
- Sinus infections

Virtual Visits with licensed behavioral health therapists are available by appointment. Get virtual care for:

- Anxiety
- Depression
- Stress management
- And more

Virtual Visit doctors can even send an e-prescription to your local pharmacy.

Activate your MDLIVE account today:

- **Call MDLIVE at 888-680-8646**
- **Go to MDLIVE.com/bcbstx**
- **Text BCBSTX to 635-483**
- **Download the MDLIVE app**

Virtual Visits may not be available on all plans. Non-emergency medical service in Montana and New Mexico is limited to interactive online video. Non-emergency medical service in Arkansas and Idaho is limited to interactive online video for initial consultation.

MDLIVE is a separate company that operates and administers Virtual Visits for Blue Cross and Blue Shield of Texas. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an independent Licensee of the Blue Cross and Blue Shield Association

9100009.1120

Employee Assistance Program (EAP)

Get the professional help you need for personal issues at no cost

The Magellan Employee Assistance Program (EAP) provides solutions to help you balance work and life through confidential and easily accessible services. Magellan EAP puts convenient resources within your reach, and that helps you—and your household members—stay healthy. **EAP benefits are provided to all Oldcastle BuildingEnvelope employees. You and your dependents do not need to be enrolled in the medical plan to participate and can access EAP benefits beginning on your hire date.** EAP services include:

- Face-to-Face Counseling

Magellan EAP can put you in touch with a licensed counselor for face-to-face visits. You and your household members are eligible for up to four visits for each personal situation. If more sessions are required you will be referred to your health insurance company for potential health benefits or to community resources for ongoing care.

- Legal Services

The EAP offers access to a free legal consultation that may last for up to 30 minutes. Simply call the EAP to request legal services on virtually any issue, including matters relating to criminal, civil, estate issues and more. If assistance is needed beyond the initial consultation you are eligible for a preferred discount rate of 25% off the attorney's normal hourly fee. Legal forms and information are also available on the EAP website. Please note matters involving disputes between members and their employer are specifically excluded from eligibility of this program.

- Financial Services

The EAP offers access to a free telephone financial consultation on topics that are important to you, including bankruptcy, budgeting, taxes, estate planning, home purchases and more. The consultation sessions have no time limitations and are available without appointment during regular business hours and by appointment at nights and weekends. Financial calculators and tools are available on the EAP website as well.

EAP toll-free number: **800.327.5049**

You can also go online: **www.magellanascend.com**

- ID Recovery

Specialists are available 24/7 to assess your risk level and then identify steps to resolve potential identity theft. All services are provided to you free of charge. This may include completing any necessary paperwork, reporting to the consumer credit agencies, and negotiating with creditors to repair debt history. Our specialists will work with you to restore your financial identity to its pre-theft status.

- Child & Elder Care Resources and Information

You and your household members can get information on child and elder care resources such as day care, in-home services, adult day care, support groups and more on the EAP website. With your plan you may call the EAP and speak with a consultant directly regarding your child and elder care needs or use the live-chat feature on the EAP website.

- Tobacco Cessation

Online Information: The EAP offers a free online education resource that will help you learn how to break the tobacco habit. The information focuses on the root emotional and physical causes of using tobacco.

- **EAP WEBSITE – www.magellanascend.com**

Provides access to a variety of resources to help you balance the demands of home and work. Log on to the web for articles, guides, interactive tools, self-assessments, financial/legal resources and more, all focused on helping you achieve your best. The website also features an online EAP provider finder tool, which you can use to find an EAP counselor.

Pharmacy Plan

Things to know about Prime Therapeutics

» Your prescription drug benefit features a formulary drug list (a list of preferred drugs). Traditional Select is the pharmacy network. Formulary is the Balanced Drug List and can be found online at **www.bcbstx.com**

» A formulary is a list of prescription drugs, both generic and brand name, that are covered by the drug plan. Formularies are subject to change periodically. Prime Therapeutics updates formularies on a twice yearly. The formulary drug list is developed by Prime Therapeutics identifying drugs that offer the greatest overall value. This may result in a brand name drug being excluded when a generic equivalent is covered. Generic drugs contain the same active ingredient(s) as a brand name drug.

» **Your pharmacy network is the Traditional Select Network. Prime has a national network of pharmacies for your convenience, which includes CVS retail stores as well as most other large chains and independent pharmacies. To access the Prime Therapeutics pharmacy locator, please visit www.bcbstx.com and register with the member ID found on the back of your ID card. You can also locate a network pharmacy using the BCBSTX Mobile App.**

Home Delivery

You could save time and money by getting maintenance medications by mail through Express Scripts Home Delivery Pharmacy. Enroll in Express Scripts Home Delivery Pharmacy to get up to a three-month supply of the medications you take regularly. Your medication will come right to your mailbox. To start home delivery, log into **www.express-scripts.com/rx** or call **833.715.0942.**

Specialty Drugs

Accredo Specialty Pharmacy is a part of your benefit program. Accredo Specialty Pharmacy provides specialty medications and some clinical support for complex conditions, including cancer, arthritis and others. To learn more about Accredo Specialty Pharmacy, call **833.721.1619** or visit **www.accredo.com.**

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

Diabetes Medication & Supplies

Preferred insulins are available on the BCBSTX website at **www.bcbstx.com**

Diabetic supplies that are considered durable medical equipment, such as meters, pumps, transmitters and sensors, will be covered under the medical plan according to medical plan criteria and limitations.

Plan Highlights

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

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

Women's Health Initiative: Contraceptives

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

PRIME THERAPEUTICS®

Prime Therapeutics Customer service, retail/home delivery
www.bcbstx.com | 800.521.2227

Accredo Specialty Pharmacy
www.accredo.com | 833.721.1619

Prime Therapeutics Programs and Helpful Information

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

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

What is Prior Authorization (PA)?

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

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

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

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

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

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

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

What are Quantity Limits (QL)?

Limit on the amount of certain medications.

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

What is Step Therapy (ST)?

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

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

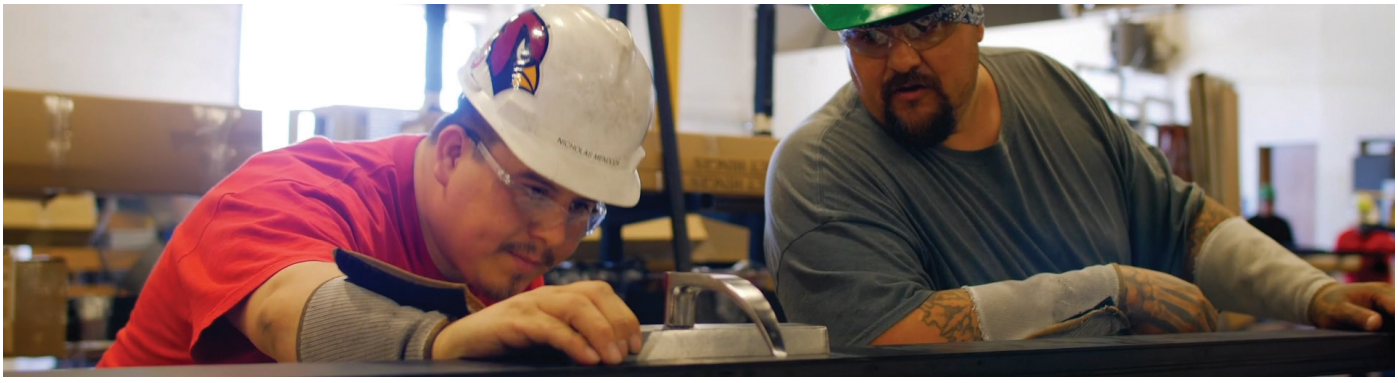
What is a Dispense as Written (DAW) Penalty?

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

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

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

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



What is a formulary?

The list of drugs available under your plan.

A formulary is a list of prescribed medications selected by your plan for their safety, cost and effectiveness. It includes both brand and generic prescription medications approved by the U.S. Food and Drug Administration (FDA). The formulary is subject to change quarterly each year. It is important to understand which prescription drugs are available to you and whether there are any other restrictions around them, such as the programs described above.

What are Specialty Medications?

High-cost medications that cover complex conditions.

If you are diagnosed with a chronic or complex health condition, like cancer, multiple sclerosis, rheumatoid arthritis or others, the specialty medications your doctor prescribes can be an important part of your treatment plan. Specialty medications may also have special handling instructions. Specialty prescriptions must be filled through the Accredo Specialty Pharmacy. They provide the resources and personalized support to help you manage your condition and help maintain or improve your health and your quality of life. Pharmacists are available 24/7 for urgent concerns.

For questions on specialty medications, call Accredo Specialty Pharmacy at **833.721.1619** or visit **www.accredo.com.**

Dental Plan

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

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

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

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

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

DELTA DENTAL®

Delta Dental
www.deltadentalins.com
800.521.2651

Vision Plan

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

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

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

EyeMed
www.eyemedvisioncare.com
866.723.0513

INNOVATIVE ANSWERS FOR TOTAL HEALTH & WELLNESS

Hear all the sweet sounds of life

Hearing loss is more common than you might think. It affects 1 in 9 Americans[1] and can come on so gradually you may not even notice it. But the good news is 95% of hearing loss can be easily treated with hearing aids.[1]

That's why we give you access to affordable hearing care discounts through Amplifon, the nation's largest independent hearing discount network – so you can enjoy all of life's sights and sounds.

YOUR HEARING DISCOUNT THROUGH AMPLIFON INCLUDES:

- 64% off hearing aids at thousands of convenient locations nationwide[2]
- Discounted, set pricing on thousands of hearing aids
- 60-day hearing aid trial period with no restocking fees
- Free batteries for 2 years with initial purchase
- 3-year warranty and loss and damage coverage

Call 877.203.0675 to find a hearing care provider near you and schedule a hearing exam today.

SEE THE GOOD STUFF

Register on eyemed.com or grab the EyeMed app (App Store or Google Play)

amplifon Hearing Health Care

[1] https://www.amplifonusa.com/hearing-loss
[2] Savings based on Amplifon Hearing Health Care average member savings data for 2020

PDF-2105-M-370

MyChoice Accounts (MCA)

Health Savings Account (HSA)

The HDHP medical plan offered by OBE meets certain IRS requirements that allow employees who enroll in it to open a Health Savings Account or HSA. An HSA allows you to contribute pretax payroll deductions that you can then use to pay for qualified expenses.

What is a High Deductible Health Plan (HDHP)?

A High Deductible Health Plan (HDHP) is a health plan that requires participants to pay 100% of claims cost up to the plan deductible. The HDHP calendar year deductible is $2,800/individual and $5,600/family. After meeting your deductible, you will then begin paying coinsurance, (typically the plan will pay 80% of In-Network claims while you only pay 20%). Claims for in-network wellness/preventive care are covered at 100% by the plan (at no cost to you) without having to meet your deductible.

The High Deductible Health Plan (HDHP) offered by OBE meets certain IRS requirements that allow employees who enroll in it to open a Health Savings Account or HSA.

What is a Health Savings Account (HSA)?

It's a pretax savings account. Money in the account can be used to pay health expenses today or invested for future healthcare expenses.

A personal bank account which you and/or your employer can contribute to tax free. The funds in your HSA may be used to pay for you and your eligible dependents' qualified medical out-of-pocket expenses. If you enroll in the HSA, OBE will contribute and the employee may contribute via payroll deduction up to annual limits set by the IRS. Employee contributions reduce your taxable income.

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

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

- You elect the OBE qualified high-deductible health plan (HDHP) for 2022.
- Your only coverage is an HDHP.
  - If you're covered under your spouse's plan and that plan is not a qualified HDHP, you are not eligible to contribute to an HSA.
- You are not covered by a traditional Healthcare FSA through your spouse.
- You are not covered by Medicare (part A or B), Tricare or VA Benefits*.
- You cannot be claimed as a dependent on another person's tax return (unless it's your spouse).

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

Why would I choose to contribute to an HSA?

HSAs are funded with tax-free deductions from your paycheck. Even if you decide not to contribute, OBE will still contribute based on how many dependents you enroll. You can invest your balance and not pay taxes on your gains. You can use it to pay for eligible healthcare expenses now or in the future. Your spouse and dependents don't need to be covered by the HDHP in order for you to use the account funds to pay for their qualified expenses.

How do I enroll?

You can enroll in the HDHP during Open Enrollment on the Benefitsolver website. If you elect the HDHP plan, you will need to answer a few questions online to ensure you are eligible to open and/or contribute to an HSA. If you are eligible, your account will automatically be opened with the banking custodian, UMB Bank.

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

Enrollment information will be provided automatically from Benefitsolver's MyChoice Accounts to the banking custodian, UMB Bank, based on your information in Benefitsolver.

As with any other banking requirement, employees will be required to comply with the **Customer Identification Program (CIP)** for identity verification. Financial institutions are required under CIP to obtain and verify specific customer data information in order to comply with the US Patriot Act of 2003. This data includes name, date of birth, SSN and residential address. In the majority of enrollments this information will pass without instance. However, any conflicting information will need to be verified by the employee. Employees may be notified during enrollment through Benefitsolver, or following the enrollment by UMB Bank if they did not satisfy CIP requirements as well as the consequences of not complying. You must satisfy this process in order to make or receive contributions to an HSA.

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

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

How do I contribute to an HSA?

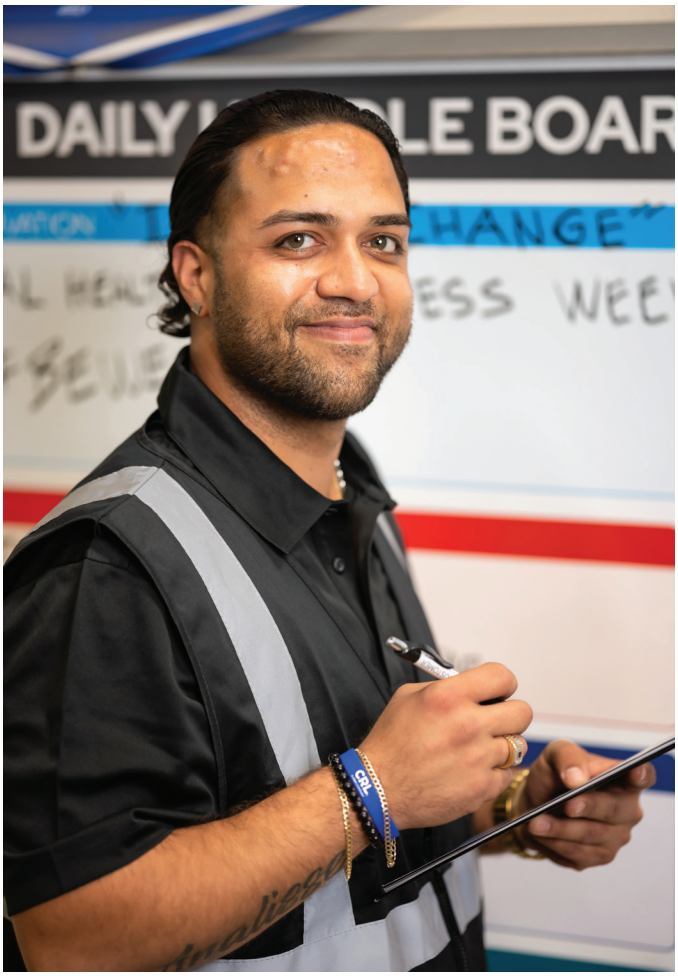
During Open Enrollment, you can elect an annual contribution amount to be deducted from your paycheck on a pretax basis. The amount deducted from your paycheck will be based on your total election divided by your benefit deduction frequency as it is set up in Benefitsolver.

OBE HSA Contributions

If you are eligible to open an HSA, OBE will contribute on your behalf regardless of whether or not you elect to contribute. Below are the annual amounts OBE will contribute each pay period based on your enrollment in the HDHP and the number of dependents you elect to cover on the plan.

Enrollment Tier	2022 IRS Annual Maximum (Oldcastle BuildingEnvelope + Member Contribution)	Oldcastle BuildingEnvelope Annual Contribution	Member Annual Contribution
Employee Only	$3,650	$500	Minimum: $0 Maximum: $3,150
Employee + Child	$7,300	$750	Minimum: $0 Maximum: $6,550
Employee + Spouse	$7,300	$750	Minimum: $0 Maximum: $6,550
Employee + Children or Employee + Family	$7,300	$1,000	Minimum: $0 Maximum: $6,300

Catch-up contributions: If you are age 55 or older as of December 31, 2022, you can contribute an extra $1,000 per year. **Annual Maximum** is subject to change by the IRS on an annual basis.



When are my HSA funds available to me?

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

Can I change my HSA contribution during the year?

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

What can I use HSA funds for?

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

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

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

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

mychoice™ Accounts

Can I rollover and transfer from my old custodian to my new MyChoice HSA Accounts?

Yes, you can rollover your HSA dollars from your current custodian bank into your MyChoice HSA Accounts at UMB Bank.

Before transferring you will want to liquidate your investments prior to rolling over. Once logged into Benefitsolver, you can navigate to your Reference Center and download the MyChoice Accounts Trustee-to-Trustee Transfer form. Once completed, you will need to send the completed form to your current HSA custodian bank. Your current custodian bank will complete the remaining portion and issue a check to UMB Bank. UMB will post your HSA dollars within 3 days of receipt once they have received your dollars from the previous custodian bank.

For help with questions, call **888.907.1440** and ask for a Health Savings Account representative.

Are there administrative fees associated with an HSA?

Yes. If you choose to invest your funds, which you are eligible to do once your balance exceeds $1,000, a $2.50 monthly administration fee, charged by UMB Bank, is deducted directly from your account balance. If you choose to enroll in another Healthcare plan option, or in the event of employment termination, you can keep your HSA. UMB Bank will charge an additional monthly administrative fee.

What are the Investment Options?

Your MyChoice HSA Accounts can earn money while saving money. Just like a traditional savings account, the money in your HSA earns interest in an FDIC insured account from which you can withdraw funds at any time. You can keep some money liquid in your account to pay for today's healthcare expenses as they arise, and you can invest the remainder of your balance to save for future healthcare expenses.

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

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

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

Your investment choices include standard investment options, which range from high, moderate, or low-risk investment choices to maximize your savings. You can invest in US Equity, International, Income, Money Market and Target Allocation Funds.

When you start investing the money in your HSA, you will not pay taxes on your gains. Your interest and investment income earned on the HSA balance are also taxfree, allowing you to build a bigger nest egg even faster.

Flexible Spending Accounts (FSA)

Businessolver is the Administrator of the Oldcastle BuildingEnvelope Flexible Spending Accounts

Setting money aside to pay for healthcare expenses

The Flexible Spending Accounts (FSAs) allow you to set aside money on a pretax basis that you can use throughout the plan year to reimburse yourself for eligible healthcare and dependent care expenses. FSAs offer you tax advantages that stretch the value of your money—the money you set aside is never taxed. You may participate in the Flex Spending Accounts (FSA) regardless of which medical plan you choose and whether you participate in the Oldcastle BuildingEnvelope Healthcare Plan or not.

You may contribute to one or more of the following FSAs:

- **Healthcare FSA –** Available for employees to set aside pretax contributions to be used to pay for any IRS eligible healthcare expense, including deductibles, copays, coinsurance, prescription drugs, dental claims or vision claims.
- **HSA-Compatible FSA –** Available for employees who participate in the HDHP in 2022 and who open and/or contribute to an HSA. The funds in this FSA are only available for dental or vision expenses until your calendar year deductible has been met and verification submitted to MyChoice Accounts.
- **Dependent Day Care FSA –** Available to employees wishing to set aside pretax dollars to pay for day care expenses for eligible dependents.

Did you know?

Enrollment in the FSA is an annual event. If you participated in the FSA in 2021, you will need to enroll during Open Enrollment to participate in 2022. Enrollment does not carry forward year to year.

Enrollment elections cannot be changed until the next enrollment period which is not until the Fall of 2022, with an effective date of January 2023. The only exception to this rule is if you have a qualified status change.

2022 Flexible Spending Account Limits:

- FSA limit increase to $2,750
- FSA carryover limit increase to $550
- HSA max contribution limit increase to $3,650 per individual and $7,300 per family

FSA Reimbursement

In general, expenses must be incurred during the plan year in which you are enrolled in order to receive reimbursement. However, both the Healthcare FSA and the Dependent Day Care FSA have special provisions for unused funds at the end of the plan year.

Eligible expenses may be reimbursed up to the full amount you've elected to contribute into your Healthcare FSA even if year-to-date contributions are less than the reimbursement. Dependent Day Care FSA expenses will only be reimbursed up to the year-to-date contribution amount.

Nondiscrimination Testing

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

Why enroll?

Everyday savings – Saving is simple. When you enroll in the program, you set aside some of your pay before taxes to use for eligible expenses.

It's covered – You can cover your copays, deductibles, dental and vision care, and prescriptions with your Healthcare FSA.

Easy – Wondering if an FSA might be a hassle? Don't. This program is built for maximum convenience, from on-the-spot access with the MyChoice FSA/HSA Accounts Card, to great time-savings features like direct payments to providers and easy online tracking.

Make it your own – It's your own account; you decide how to use it. You can pick just a Healthcare FSA or a Dependent Day Care FSA, or both—you choose how much to set aside in each.

Healthcare FSA

The Healthcare FSA is available to employees who wish to set aside money on a pretax basis for out-of-pocket medical, dental, and vision expenses incurred by you, your spouse, or your dependent children. If you participate in the Health Savings Account, see below for information on the HSA-Compatible FSA.

A wide variety of expenses can be covered by a Healthcare FSA. A few examples of eligible expenses include:

- Deductibles, copays and coinsurance for medical, dental, or vision expenses
- Prescription drugs
- Any IRS eligible expense

For questions regarding eligible expenses, contact your Oldcastle BuildingEnvelope Benefits or go online to your Benefitsolver site at **www.myOBEbenefits.com**

How It Works

You may elect to contribute a minimum of $250 to a maximum of $2,750 to your Healthcare FSA per plan year. The amount you elect to contribute is automatically deducted from your paycheck in equal installments throughout the year and applied to your Healthcare FSA. The money you contribute to the account on a pretax basis is not taxed when you use it for eligible expenses.

Healthcare FSA funds may be used to pay eligible medical expenses for you and your eligible dependents. Even if you do not cover your spouse or dependents under Oldcastle BuildingEnvelope' benefit plans, you can claim their eligible expenses through your Healthcare FSA as long as they meet the definition of dependents.

In exchange for the tax advantages of the Healthcare FSA, the IRS applies some strict rules regarding its use:

- Unused funds greater than $550 remaining in your Healthcare FSA account after the plan year will be forfeited.
- Payroll deductions cannot be changed before the end of the plan year unless you have a qualified status change.
- Funds cannot be transferred from your Healthcare FSA to your Dependent Day Care FSA, or vice versa.

HSA-Compatible FSA

If you participate in the HDHP option in 2022 and contribute to a Health Savings Account (HSA), and you wish to participate in a Flexible Spending arrangement, you may only contribute to an HSA-Compatible FSA. In an HSA-Compatible FSA, your FSA funds may only be used to pay for qualified Dental and Vision expenses. No Medical or Prescription claims or reimbursements can be requested from an HSA-Compatible FSA until you have satisfied your calendar-year deductible.

In addition, if you have rollover FSA funds from the 2021 plan year, your funds must roll over into the HSA-Compatible FSA if you enroll in the HDHP and elect to participate in the HSA.

benefitsolver®

www.myOBEbenefits.com
888.907.1440

Healthcare FSA – HSA-Compatible FSA – $550 Carryover

The Healthcare FSA will allow you to automatically carry over up to $550 of any balance remaining at the end of 2022 to be used in 2023. The $550 carryover will not affect the $2,750 limit for contributions in 2023. No need to rush to spend the carryover dollars—there is no deadline in 2023 to spend the amount carried over.

The minimum balance required for carryover is $10 for participants who do not enroll in the Health Care Flexible Spending Account for the next plan year.

The Healthcare Card and How It Works

The Healthcare debit card works much like a credit card that allows you to access funds at the point of sale to pay for qualified healthcare expenses. The card is linked directly to all of your MyChoice Accounts, including FSA, HSA-compatible FSA and HSA.

A few things to remember:

- You will receive only one MyChoice FSA/HSA Accounts Card for all your accounts.
- Your annual election amount is available January 1 for your FSA and HSA-Compatible FSA.
- Your HSA balance will be based on how much you have contributed year-to-date.

If you have an HSA-compatible FSA and a Health Savings Account (HSA), all medical and prescription drug card swipes will pull from the HSA because the HSA-Compatible FSA may only be used for Dental and Vision expenses until you have met your HDHP medical plan deductible. However, once you have met your HDHP deductible and provide the "HDHP Deductible Met" form and your EOB to MyChoice Accounts, you will be able to use your HSA-Compatible FSA for medical and prescription drug expenses.

Remember that no auto-reimbursement will be issued from your HSA. If you would like to take advantage of auto-reimbursement, you must be enrolled in the FSA and you must choose not to activate your MyChoice FSA/HSA Accounts Card.

For questions regarding any of your MyChoice Accounts:

- Ask Sofia through your Benefitsolver site at **www.myOBEbenefits.com** or through the MyChoice Mobile App
- Call the Oldcastle BuildingEnvelope Benefits Helpline at **888.907.1440**

Save your receipts! Even when your card is approved, a detailed receipt may still be requested. Receipts are easy to submit online, via the MyChoice Mobile App, or by completing a Card Use Verification form.

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

Eligible Expenses...

Eligible expenses include direct supervision of the dependent(s) and expenses for household services. Most kinds of direct supervision are covered, including:

- Care in a dependent care center. If the facility provides care for over six individuals, the center must comply with applicable local laws and regulations
- Dependent day care provided by an individual in your home or theirs
- Dependent day care provided in an educational institution

benefitsolver®

www.myOBEbenefits.com
888.907.1440

Dependent Day Care FSA

The Dependent Day Care FSA is available to employees wishing to set aside pretax dollars to pay for day care expenses for eligible dependents. Eligible dependents are defined as children under the age of 13 who qualify as dependents on your federal income tax return, or a disabled spouse or disabled dependent age 13 or older who is physically or mentally incapable of self-care. Verification of disability is required. Dependent care must be necessary to allow the adults in your household to work, or in some cases attend school. If you are married, both you and your spouse must be working.

The minimum balance required for carryover is $10 for participants who do not enroll in the Health Care Flexible Spending Account for the next plan year.

How it Works

You may elect to contribute a minimum of $250 to a maximum of $5,000 to your Dependent Day Care FSA ($2,500 if married and filing a separate return). The amount you elect to contribute is automatically deducted from your paycheck and deposited in your Dependent Day Care FSA. The money you contribute to the account on a pretax basis is not taxed when you use it for reimbursements. In exchange for the tax advantages of the Dependent Day Care FSA, the IRS applies some strict rules regarding its use:

- Unused funds remaining in your Dependent Day Care FSA account after the grace period will be forfeited.
- Payroll deductions cannot be changed/stopped before the end of the plan year unless you have a qualified status change.

If you have dependent day care expenses, you may qualify for a special tax credit on your income tax return. However, you cannot claim the income tax credit for expenses you pay with money from your Dependent Day Care FSA. Because of this, it's important to determine which option will give you the greatest tax savings. You might want to check with your tax advisor or the IRS before enrolling in the Dependent Day Care FSA.

Dependent Day Care FSA – Grace Period

You have a grace period until March 15 of the following year in which you may incur expenses using your previous year's FSA funds. You will have until March 31 (including the grace period) to apply for reimbursement of eligible expenses. Any funds remaining in your Dependent Day Care FSA after March 31 that could have been used for eligible expenses incurred during the previous year will be forfeited, as required by the IRS.

Life Insurance

Providing financial security to your family and/or beneficiaries if you die while employed with Oldcastle BuildingEnvelope.

Basic Life and AD&D Benefits for Employee

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

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

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

Optional Life for Employees

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

Guarantee Issue

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

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

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

Optional Life for Spouses

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

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

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

Optional Life for Dependents

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

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

Monthly Rates Per $10,000 of Coverage

Attained Age	Non-Tobacco	Tobacco Use
Under Age 25	$0.510	$0.620
25-29	$0.620	$0.710
30-34	$0.820	$0.950
35-39	$0.930	$1.070
40-44	$1.030	$1.190
45-49	$1.540	$1.870
50-54	$2.370	$2.860
55-59	$4.420	$5.590
60-64	$6.790	$8.930
65-69*	$13.070	$17.880
70-74*	$21.190	$29.000
75+	$21.190	$29.000

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

Did You Know?
If you leave Oldcastle BuildingEnvelope, you will have the option to port or convert your life insurance. This means you may continue to purchase the insurance by paying the premiums on your own. You have only 90 days from your termination date to transition the plan. Contact Unum for more information.

unum sm

www.unum.com
866.799.1054

Calculating Your Optional Life Cost

To calculate your monthly cost for optional life insurance, use the following formula:

Follow these steps to calculate your monthly rate for optional life insurance coverage:

1. Enter the amount of coverage you want to elect (in $10,000 increments): $_____ (1)
2. Divide the amount in (1) by 10,000 and enter the units here: $_____(2)
3. Enter your monthly rate of coverage from the rate chart above: $_____(3)
4. Multiply the amount in (2) by the amount in (3) and enter the result here.
   This is your monthly cost for the optional life coverage you are electing: $_____(4)

Calculating Your Spouse Life Cost

1. Enter the amount of coverage your spouse wants to elect: $_____(1)
   (Spouses can elect $10,000 increments, see limits above)
2. Divide the amount in (1) by 10,000 and enter the result here: $_____(2)
3. Enter the monthly rate of coverage from the chart above: $_____(3)
4. Multiply the amount in (2) by the amount in (3) and enter the result here:
   This is your Spouse's monthly cost for the optional life coverage. $_____(4)

NOTE: During the new hire period, you receive coverage of one times your annual base pay rounded up to the nearest $1,000 up to a maximum benefit of $500,000. Note: Amounts over $50,000 will be taxed as imputed income. New hires are eligible for up to $300,000 in coverage without evidence of insurability during the initial enrollment period. Spouses of new hires are eligible for up to $50,000 in coverage without evidence of insurability during the initial enrollment period.

After this open enrollment period Evidence of Insurability is required for any new entrants (new entrants are current employees who are electing optional life insurance for the first time for themselves and/or their spouse) for optional life insurance. Any increase in spouse coverage requires satisfactory Evidence of Insurability. Evidence of Insurability must be submitted to Unum by applying online at **www.myOBEbenefits.com** for approval.

Optional Life Insurance Plan Additional Information

Coverage is based on annual earnings
Employee annual earnings as of October 1 of each year are used to calculate rates and determine coverage for the following plan year commencing on January 1.

Rate change due to annual age banding
Employee age as of January 1 of each year are used to calculate rates and determine coverage for the following plan year commencing on January 1.

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

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

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

Portability/Conversion option for dependents turning age 26
Dependent children, who attain age 26 during the plan year, will be covered on the Optional Dependent Life Plan through the end of the calendar year of their 26th birthday.

The employee or dependent will have 30 days after the end of the plan year (or by the end of January) to contact Unum about portability/conversion options. No additional notifications will be provided.

Short-Term and Long-Term Disability Plans

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

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

Questions	Short-Term Disability (STD)	Long-Term Disability (LTD)
Who pays for the coverage?	Oldcastle BuildingEnvelope	Oldcastle BuildingEnvelope
What is the benefit?	60% of weekly earnings up to $2,000 (subject to taxes)	60% of monthly earnings up to $10,000
How are my benefits calculated?	• **For Salaried employees,** your benefit calculation is determined by looking at your gross monthly income in effect as of October 1 of the prior year. • **For Hourly employees,** your benefit calculation is determined using your hourly rate of pay as of October 1 of the prior year multiplied by 2,080 hours and then divided by 12 months. • **For Commissioned employees** your gross monthly income from your Employer in effect as of October 1 of the prior calendar year just prior to your date of disability. It is calculated as the sum of your annual base salary (if applicable) as of October 1 and income actually received from commissions for the period of October 1 through September 30 of the prior calendar year divided by 12 months.	
Elimination Period	7 days for Illness and Injury	26 weeks
How often will I receive my disability income?	Weekly	Monthly
How do I report a disability claim?	Telephonically **866.799.1054** or online at **www.unum.com**	Telephonically **866.799.1054** or online at **www.unum.com.** If you are receiving benefits for STD, your claim will be transferred to LTD automatically. If you are on Workers Compensation, you will need to initiate an LTD claim if you have missed 90 days and expected to continue to be disabled.
Must I communicate with my local HR/Benefit Administrator to coordinate my leave?	Yes, as you could also be eligible for benefits under the FMLA.	Yes, so you can determine if anything changes with your health and other related benefits when you start receiving LTD benefits.
How is the FMLA process handled?	This will be handled by Unum and your local HR/ Benefit Administrator to coordinate your leave.	FMLA may not apply once you start receiving LTD benefits, but if you still have FMLA-related leave available, you will still need to communicate with Unum and the local HR/Benefit Administrator to coordinate your leave.
Will my disability benefits offset with benefits available with State Disability?	Yes, if you live in California, New York, New Jersey, Rhode Island, Hawaii, or Puerto Rico the amounts you are eligible to receive will offset against the STD amount.	Yes, if you live in California, New York, New Jersey, Rhode Island, Hawaii, or Puerto Rico the amounts you are eligible to receive will offset against the LTD amount.

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

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

Unum
www.unum.com
866.799.1054

Oldcastle BuildingEnvelope 401(k) Retirement Plan

Plan Provisions	
Auto Enrollment	New employees will be subject to automatic enrollment at a 5% pretax deferral rate on their eligibility date unless they opt out of participation. Employees will receive a notice 30 days prior to their eligibility date notifying them of the auto enrollment.
Eligibility	**Employee Deferral Contribution:** First day of the month after 90 days of employment **Employer Match Contribution:** First day of the month after meeting all eligibility requirements One year of service from date of hire
Employee Contribution	You may contribute in whole percentage amounts from 1% to 75% on a pretax and/or Roth basis, subject to IRS maximum limits
Employer Contribution	**Matching contribution:** Oldcastle BuildingEnvelope will match 100% of the first 5% you contribute
Vesting	
Employee Deferral Contribution	Immediately
Employer Match Contribution	Immediately
Administered by	Fidelity Investments | 800.835.5097 | www.401k.com

Some groups including unions may have a different contribution schedule, different matching contributions, or may not be eligible for the plan. Please contact your local HR/Benefits Representative with questions regarding plan details.

401(k) Plan Highlights

This summary is intended to provide you with general information about the retirement benefits provided for you by Oldcastle BuildingEnvelope. For additional information about the Oldcastle BuildingEnvelope 401(k) Plan (the Plan), visit Fidelity NetBenefits® at **www.401k.com** or call **800.835.5097**. Please keep in mind that some groups including unions may have different eligibility requirement or contribution schedules. You may want to consult your local HR representative for plan specific information.

Who is eligible?

Your eligibility to participate in the Plan depends on the date you were first hired by a participating employer, your status in a group of employees covered by the Plan, and the types of contributions involved. You will become eligible to participate in the plan on the first day of the month following the date you turn 18 and complete 90 days of service with your employer. You will be eligible for safe harbor matching on the first day of the month following the date you turn 18 and complete one year of service (generally, 1,000 hours during the 12-month period beginning on your date of hire with your employer or a related company). You are not eligible for safe-harbor matching contributions if you are subject to a collective bargaining agreement that does not provide for you to receive such contributions. Other Plan provisions and limitations may be governed by the terms of your collective bargaining agreement.

Automatic Enrollment

Eligible employees will be automatically enrolled on the first day of the calendar month following the day you have attained age 18 and complete 90 days of service with a participating employer. **You will have 5% of your Plan compensation withheld from your pay and contributed to the Plan as 401(k) contributions.** Unless you choose investment options, the automatic 401(k) contributions will be invested in the Plan's default investment fund. This percentage will remain constant from Plan year to Plan year unless you change it.

Remember, you have the right to elect out of automatic enrollment. If you want to increase or decrease your 401(k) contributions, invest in a different investment fund, or have no contributions made to the Plan, you can make an election by calling the Fidelity Retirement Benefits Line at **800.835.5097** or online through Fidelity NetBenefits® at **www.401k.com**.

How do I enroll in the Plan?

Log on to Fidelity NetBenefits® at **www.401k.com** or call the Fidelity Benefits Center at **800.835.5097** to enroll in the Plan.

When is my enrollment effective?

Your enrollment becomes effective once you elect a deferral percentage, which initiates deduction of your contributions from your pay. These salary deductions will generally begin within 1-2 pay periods after we receive your enrollment information, or as soon as administratively possible.

How do I designate my beneficiary?

If you have not already selected your beneficiaries, or if you have experienced a life changing event such as a marriage, divorce, birth of a child, or a death in the family, it's time to consider your beneficiary designations. Fidelity's Online Beneficiaries Service, available through Fidelity NetBenefits®. offers a straightforward, convenient process that takes just minutes. Simply log on to NetBenefits® at **www.401k.com** and click on "Beneficiaries" in the "About You" section of "Your Profile". If you do not have access to the internet or prefer to complete your beneficiary information by paper form, please contact **800.835.5097**. Your beneficiary designation will not transfer from your prior plan.

How much can I contribute?

Through automatic payroll deduction, you can contribute between 1% and 75% (in 1% increments) of your eligible pay on a pretax and/or Roth basis, up to the annual IRS dollar limits. Annual additions to the plan (your contributions and company contributions combined) may not exceed 100% of your pay or $61,000 for 2022 (whichever is less). In addition, you can automatically increase your retirement savings plan contributions each year through the Annual Increase Program, up to 75% of pay. You can sign up by logging on to Fidelity NetBenefits® at **www.401k.com** and click on "Contribution Amount" or by calling the Fidelity Benefits Center at **800.835.5097**. Employees determined to be highly compensated may have additional limitations.

What is the Roth after-tax contribution option?

The Plan allows you to make Roth after-tax contributions. These contributions are taxed when contributed. When withdrawn, both the contributions and associated earnings are completely tax free as long as the withdrawal is a qualified distribution. A qualified distribution, in this case, is one that is taken at least five tax years after your first Roth after-tax contribution and after you have attained age 59½, or become disabled or die. You can elect to contribute between 1% and 75% of your eligible pay as designated Roth after-tax contributions and/or pretax contributions, up to the annual IRS dollar limits.

What are the maximum IRS annual contribution limits?

For 2022 the IRS pretax and/or Roth contribution limit is $20,500 for participants under age 50. The 2022 pretax catch-up contribution limit is an additional $6,500 for participants age 50 and older or a total of $27,000.

What "catch-up" contribution can I make?

As long as you have reached or will reach age 50 during the plan year and have made the maximum plan or IRS pretax and/or Roth contribution of $20,500 your deferral percentage may continue to defer up to the annual catch-up limit of $27,000. These will be automatically classified as catch-up contributions. A separate catch-up contribution election is not necessary. Catch-up contributions are made through payroll deduction, the same as regular contributions.

Does the Company make a matching contribution to my account?

OBE helps your retirement savings grow by matching your contributions. OBE will match 100% of each pretax and/or Roth dollar you contribute on the first 5% of pay that you defer to your Plan. In general, employees must be employed for 12 months from date of hire to meet the initial eligibility for matching contributions. Matching contributions will begin on the 1st day of the month following eligibility.

Company True-Up Contribution

The Company will make an additional discretionary year-end "true-up" employer matching Contribution on your behalf. A "true up" employer matching contribution will be calculated after year-end to ensure that you receive the maximum company matching contribution that you are eligible for (based on your average contributions throughout the year).

Plan Compensation

Contributions to the Plan are based on Plan compensation. Your "Plan Compensation" that is eligible for 401(k) contributions consists of all wages paid to you as an eligible employee for services rendered as reported on your Form W-2, exclusive of reimbursements and other expense allowances, fringe benefits, moving expenses, deferred compensation, welfare benefits and bonuses. Plan compensation does not include severance pay. Plan compensation includes any amounts that would have been included in your compensation if they had not received special tax treatment because they were deferred under the Plan, a medical reimbursement plan, dependent care plan or for qualified transportation or parking expense reimbursements. Tax rules limit the amount of compensation that may be taken into account as plan compensation each year $305,000 for 2022.

When am I vested?

You are always 100% vested in your pretax and/or Roth contributions, rollover contributions, company matching contributions, and any associated earnings.

What are my investment options?

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

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

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

Can I take a loan from my account?

Although your plan account is intended for the future, you may borrow from your account for any reason. Generally, the Plan allows you to borrow up to 50% of your pretax account balance and rollover account balance. The minimum loan amount is $1,000, and a loan can not exceed the lessor of $50,000 or 50% of your pretax and rollover account balance. You then pay the money back into your account, plus interest, through after-tax payroll deductions. Any outstanding loan balances over the previous 12 months may reduce the amount you have available to borrow. You may have one loan outstanding at a time. The cost to initiate a loan is $50, and there is a quarterly maintenance fee of $6.25. The initiation and maintenance fees will be deducted directly from your individual plan account. If you fail to repay your loan (based on the original terms of the loan), it will be considered in "default" and treated as a distribution, making it subject to income tax and possibly to a 10% early withdrawal penalty. Defaulted loans may also impact your eligibility to request additional loans. Be sure you understand the Plan guidelines before you initiate a loan from your plan account. To learn more about or request a loan, log on to **www.401k.com** or call the Fidelity Benefits Center at **800.835.5097**.

Can I make withdrawals from my account?

Withdrawals from the Plan are generally permitted when you terminate your employment, retire, reach age 59½, become permanently disabled, or have severe financial hardship as defined by your Plan. The taxable portion of your withdrawal that is eligible for rollover into an individual retirement account (IRA) or another employer's retirement plan is subject to 20% mandatory federal income tax withholding, unless it is rolled directly over to an IRA or another employer plan. (You may owe more or less when you file your income taxes.) If you are under age 59½, the taxable portion of your withdrawal is also subject to a 10% early withdrawal penalty, unless you qualify for an exception to this rule. To learn more about and/or to request a withdrawal, log on to Fidelity NetBenefits® at **www.401k.com** or call the Fidelity Benefits Center at **800.835.5097**. The plan document and current tax laws and regulations will govern in case of a discrepancy. Be sure you understand the tax consequences and your plan's rules for distributions before you initiate a distribution. You may want to consult your tax adviser about your situation. When you leave the Company, you can withdraw contributions and any associated earnings or, if your vested account balance is greater than $5,000, you can leave contributions and any associated earnings in the Plan. After you leave the Company, if your vested account balance is equal to or less than $1,000, it will automatically be distributed to you. If your account balance is greater than $1,000 but less than $5,000, your account will be rolled over to a Fidelity Individual Retirement Account (IRA).

How do I access my account?

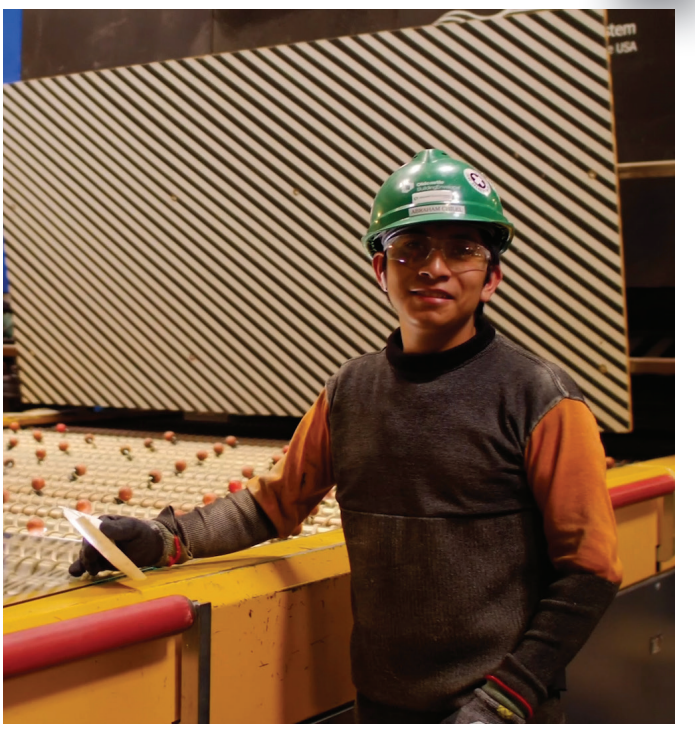
You can access your account online through Fidelity NetBenefits® at **www.401k.com** or call the Fidelity Benefits Center at **800.835.5097** to speak with a representative or use the automated voice response system, virtually 24 hours, 7 days a week.

When will I receive my statement?

Quarterly statements are available online. Upon initial login to NetBenefits participants will be requested to consent to online delivery. Participants who decline consent will be reverted to paper statement delivery. All other participants (those who have not logged onto NetBenefits) will default to online statement delivery. Participants have the option to revert back to paper at any time by making an election through Fidelity NetBenefits® at **www.401k.com** or calling the Fidelity Benefits Center at **800.835.5097**. Participants using online statement delivery (either by default or by their election) will be sent a Notice of Statement Availability (NOSA) in the mail annually.

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

Once you enroll, you will receive a welcome communication that provides details about managing your account. You can also learn about loans, exchanges, and more, online through Fidelity NetBenefits® at **www.401k.com**. In particular, you can access loan modeling tools that illustrate the potential impact of a loan on the long-term growth of your account. You will also



find a withdrawal modeling tool, which shows the amount of federal income taxes and early withdrawal penalties you might pay, along with the amount of earnings you could potentially lose by taking a withdrawal. You can also obtain more information about loans, withdrawals, and other plan features, by calling the Fidelity Benefits Center at **800.835.5097** to speak with a representative or use the automated voice response system, virtually 24 hours, 7 days a week.

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

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

How do I obtain investment option and account information?

The Company has appointed Fidelity to provide additional information on the investment options available through the Plan. Also, a statement of your account may be requested by phone at **800.835.5097** or reviewed online at Fidelity NetBenefits®.

Updated 04/2022

Contact Information

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

Enrollment & Eligibility

benefitsolver

888.907.1440
www.myOBEbenefits.com

If You Need:

- Benefit enrollment assistance
- Verification of eligibility and coverage
- General benefit questions
- Benefit Plan coverage and elections
- Dependent verifications
- COBRA support or questions
- Re-setting Benefitsolver password
- Warm transfer to other OBE vendors
- Questions on Flexible Spending Healthcare (HC-FSA), Dependent Care (DC-FSA) and Health Savings Accounts (HSA)

Medical Claims

BlueCross BlueShield of Texas

800.521.2227
www.bcbstx.com

If You Need:

- Medical ID card
- Print your card from the website
- Find a Medical provider
- Pre-certification
- Medical claims status
- Specific medical benefit questions & details
- Medical claims history
- EOB statement (Explanation of Benefits)
- Assistance with medical claims issues, including 3-way calls with a provider or vendor

Prescription Drug Claims

PRIME THERAPEUTICS®

800.521.2227
www.myprime.com

If You Need:

- Print your Prescription Drug ID Card from the app or website
- Pharmacy locations
- Information on retail 90-day refills
- Home Delivery (mail order)
- Prescription Drug Formulary
- Rx history
- Specialty Drugs:

Accredo Specialty Pharmacy
833.721.1619
www.accredo.com

Dental Claims

DELTA DENTAL®

800.521.2651
www.deltadentalins.com

If You Need:

- Dental ID Card
- Print your card from the website
- Find a Dental provider
- Dental Coverage details
- Dental claims status

Vision Claims

EyeMed

866.723.0596
www.eyemedvisioncare.com

If You Need:

- Vision ID Card
- Print your card from the website
- Find a Vision provider
- Vision Coverage details
- Vision claim status

Life & Disability Claims

UNUM℠

866.799.1054
www.unum.com

If You Need:

- Life and/or disability claim status
- File a new leave of absence or disability claim
- Report intermittent hours of absence
- Check on status of existing leave of absence and/or disability claim
- Check on status of existing life and/or AD&D claim
- To request portability/conversion paperwork: **866.220.8460**

Employee Assistance (EAP)

Magellan HEALTH℠

800.327.5049
www.magellanhealth.com

If You Need:

- Face-to-face Counseling
- Legal Services
- Financial Services
- ID Recovery
- Legal Services

MDLive

MDLIVE® Virtual Care, Anywhere.

888.680.8646
www.MDLive.com/bcbstx

If You Need:

- 24/7 Video visit with doctor to discuss common health conditions
- Counseling services

Retirement – 401(k)

Fidelity netBenefits℠

800.835.5097
www.401k.com

If You Need:

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

Legally Required Notices

Women's Health and Cancer Rights Act Required Annual Notice

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

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

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

HIPAA Notice of Special Enrollment Rights

Loss of Other Coverage

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

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

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

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

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

HIPAA Privacy Notice

Notice of Privacy Practices

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

Name of Health Plan: Oldcastle BuildingEnvelope Healthcare Plan (the "Plan")

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

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

Our Commitment Regarding Health Information Privacy

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

Privacy Obligations of the Plan

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

How the Plan May Use and Disclose Health Information About You

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

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

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

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

To the Plan Sponsor. The Plan may disclose your PHI to Oldcastle BuildingEnvelope in certain circumstances. First, the Plan may disclose enrollment information to Oldcastle BuildingEnvelope. Second, the Plan may disclose summary health information to Oldcastle BuildingEnvelope so that Oldcastle BuildingEnvelope can obtain premium bids or modify, amend, or terminate the Plan. Third, the Plan may disclose PHI to Oldcastle BuildingEnvelope to perform Plan administrative functions and Oldcastle BuildingEnvelope will not further use or disclose that PHI except as permitted or required by How the Plan May Use and Disclose Health Information About You

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

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

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

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

To the Plan Sponsor. The Plan may disclose your PHI to Oldcastle BuildingEnvelope in certain circumstances. First, the Plan may disclose enrollment information to Oldcastle BuildingEnvelope. Second, the Plan may disclose summary health information to Oldcastle BuildingEnvelope so that Oldcastle BuildingEnvelope can obtain premium bids or modify, amend, or terminate the Plan. Third, the Plan may disclose PHI to Oldcastle BuildingEnvelope to perform Plan administrative functions and Oldcastle BuildingEnvelope will not further use or disclose that PHI except as permitted or required by the Plan documents and by law. Only employees involved in the administration of the Plan will have access to your PHI to perform Plan administrative functions, including (but not limited to) enrollment, payroll deductions, evaluating potential new insurers or service providers to the Plan, assisting participants with claims disputes and questions, and coordinating COBRA continuation coverage.

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

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

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

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

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

Public Health Risks. The Plan may disclose health information about you for public health activities. These activities include preventing or controlling disease,

injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products.

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

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

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

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

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

Other Uses and Disclosures of Health Information

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

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

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

Minimum Necessary Standard

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

Your Rights Regarding Health Information About You

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

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

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

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

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

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

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

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

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

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

A Note About Personal Representatives

You may exercise your rights through a personal authorized representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

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

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

Changes to this Notice

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

Complaints

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

Contact Information: If you have any questions about this notice, please contact the Privacy Officer at
Oldcastle BuildingEnvelope
Attn: HIPAA Privacy Officer,
5005 LBJ Freeway, Suite 1050
Dallas, TX 75244

Updated and effective September 23, 2013.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Oldcastle BuildingEnvelope Benefit Help Line at ___.___.____
.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Oldcastle BuildingEnvelope	4. Employer Identification Number (EIN) 75-2196684	
5. Employer address 5005 LBJ Freeway Suite 1050	6. Employer phone number 888.907.1440	
7. City Dallas	8. State Texas	9. ZIP code 75244
10. Who can we contact about employee health coverage at this job? Oldcastle Building Envelope Benefit Help Line		
11. Phone number (if different from above)		

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

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

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

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

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

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

☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **866.444.EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your state for more information on eligibility.

ALABAMA – Medicaid

http://myalhipp.com
855.692.5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
http://myakhipp.com/ | 866.251.4861
CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid

http://myarhipp.com
855.MyARHIPP (855.692.7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov

COLORADO – Medicaid and CHIP

Health First Colorado (Colorado's Medicaid Program)
https://www.healthfirstcolorado.com
Member Contact Center: 800.221.3943 | State Relay 711
Child Health Plan Plus (CHP+)
https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
Customer Service: 800.359.1991 | State Relay 711
Health Insurance Buy-In Program (HIBI)
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 855.692.6442

FLORIDA – Medicaid

www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
877.357.3268

GEORGIA – Medicaid

A HIPP Website: https://medicaid.georgia.gov/
health- insurance-premium-payment-program-hipp
678.564.1162, Press 1
GA CHIPRA Website: https://medicaid.
georgia.gov/programs/third-party- liability/
childrens-health-insurance-program-reauthorization-act-2009-chipra
678.564.1162, Press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
http://www.in.gov/fssa/hip/ | 877.438.4479
All other Medicaid
https://www.in.gov/medicaid/ | 800.457.4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366
Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563
HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp |
888.346.9562

KANSAS – Medicaid

https://www.kancare.ks.gov/
800.792.4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
855.459.6328 | KIHIPP.PROGRAM@ky.gov
KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718
Medicaid: https://chfs.ky.gov

LOUISIANA – Medicaid

www.medicaid.la.gov or www.ldh.la.gov/lahipp
888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)

MAINE – Medicaid

Enrollment: https://www.maine.gov/dhhs/ofi/applications-forms
800.442.6003 | TTY: Maine relay 711
Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/
applications-forms
800.977.6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

https://www.mass.gov/masshealth/pa
800.862.4840

MINNESOTA – Medicaid

https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-
care-programs/programs-and-services/other-insurance.jsp
800.657.3739

MISSOURI – Medicaid

http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
573.751.2005

MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/oii/hipp.htm 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/ 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075
PENNSYLVANIA – Medicaid
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462

RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org 800.250.8427
VIRGINIA – Medicaid and CHIP
https://www.coverva.org/en/famis-select https://www.coverva.org/hipp/ Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

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

OMB Control Number 1210-0137 (expires 1/31/2023)

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Oldcastle BuildingEnvelope has determined that the prescription drug coverage offered by the Oldcastle BuildingEnvelope Healthcare Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

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

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

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

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

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

For more information about your options under Medicare prescription drug coverage:

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

For more information about Medicare prescription drug plans:

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

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

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

Date:	October 1, 2022
Name of Entity/Sender:	Oldcastle BuildingEnvelope
Contact:	Oldcastle BuildingEnvelope Healthcare Plan
Address:	5005 LBJ Freeway, Suite 1050 Dallas, TX 75244

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

Introduction

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

What Is COBRA Continuation Coverage?

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

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

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

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

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

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

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

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

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

When Is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

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

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

How Is COBRA Coverage Provided?

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

Disability Extension of 18-Month Period of Continuation Coverage

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

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

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

If You Have Questions

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

Keep Your Employer Informed of Address Changes

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

Plan Contact Information

If you do not understand any part of this summary notice or have questions regarding the information or your obligations, please contact us by phone at **888.907.1440** or submit a written request to:

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

Important Benefit Disclosures Under ERISA

Dear Participants in the Oldcastle BuildingEnvelope Health and Welfare Benefit Plans:

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

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

To access these documents, please visit our benefits website at **www.myOBEbenefits.com** and login in using your User Name and Password. If you have questions about registering for the site or how to log in, please contact the **Oldcastle BuildingEnvelope Benefits Helpline at 888.907.1440**.

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

If you cannot access these documents via the website, please contact the **Oldcastle BuildingEnvelope Benefits Helpline**, by mail at **1025 Ashworth Road, Suite 101, West Des Moines, IA 50265,** or by phone at **888.907.1440.**

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

You have a right to receive a paper version of any electronically transmitted document at no charge. Please contact the **Oldcastle BuildingEnvelope Benefits Helpline,** by mail at **1025 Ashworth Road, Suite 101, West Des Moines, IA 50265,** or by phone at **888.907.1440** to obtain a paper copy.

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

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

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting