2027 Employee Benefits

NON-BARGAINING

Lhoist North America

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Working together is what makes Lhoist North America a success, and this teamwork extends to your benefits. We provide options to support your family's overall wellbeing. This guide offers details on your 2027 benefits. Please contact your Human Resource Business Partner or the LNA Benefits Team with any questions.

See **page 39** for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to Lhoist North America. This Guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Eligibility and Enrollment

Lhoist North America's benefits are designed to support your unique needs.

Eligibility

If you are a full-time employee of Lhoist North America who is regularly scheduled to work 30 or more hours per week, you are eligible to participate in medical, dental, vision, life and disability plans, and additional benefits.

When Does Coverage Begin?

Your elections are effective on your date of hire. Benefits cannot be changed until the next open enrollment period unless you experience a Qualifying Life Event (QLE).

Enrollment Deadline

You will have 30 days from the date of hire to submit your elections along with any supporting documents required to confirm the Qualifying Life Event.

Note

Open Enrollment is your annual chance to choose your benefits, unless you have a Qualifying Life Event, such as marriage or the birth/adoption of a child.

Dependents

Dependents eligible for coverage include:

- Your legal spouse (or common-law spouse where recognized).
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom you or your spouse have legal guardianship).
- Dependent children 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).
- Verification of dependents eligibility is required upon enrollment, through Dependent Specialists, Inc. (DSI).

Important Contacts

Medical
BCBSTX
Health Advocacy Solutions
888-423-5475
www.bcbstx.com
PPO Policy #: 217467
HDHP Policy #: 273140

Telemedicine
Teladoc
800-835-2362
teladoc.com/bcbstx

Dental
Delta Dental
800-521-2651
www.deltadentalins.com
Policy #: 20165

Vision
VSP
800-877-7195
www.vsp.com
Policy #: 12133312

Retirement
T. Rowe Price
800-922-9945
rps.troweprice.com
Policy #: 106041

Supplemental Health Benefits
UNUM
Enrolled: 800-635-5597
Policy #: R0142349

Health Savings Account
HSA Bank
855-731-5220
www.hsabank.com
askus@hsabank.com

Flexible Spending Accounts
Navia Benefit Solutions
800-669-3539
www.naviabenefits.com
Employer Code: L3N

Life and AD&D
Reliance Matrix
800-351-7500
reliancematrix.com/individuals
Basic Life / AD&D Policy #: 1500002186
Voluntary Life Policy #: 1500002185
Voluntary AD&D / VAR Policy #: 1610001084

Disability/Leave of Absence
Reliance Matrix
877-202-0055
www.matrixabsence.com/login/
LTD Policy #: 130000614
STD Policy #: 1370000303

Employee Assistance Program
AllOne Health
Call: 855-775-4357
Online: http://allonehealth.com/reliance-matrix
Company Code: RSLI859

Identity Theft
LifeLock
To Enroll: 866-917-2555
Enrolled: 800-607-9174
www.lifelock.com
Policy #: E0005739

Lhoist North America Benefits Team
5600 Clearfork Main Street, Suite 300
Fort Worth, TX 76109
800-286-0134
lna.benefits@lhoist.com

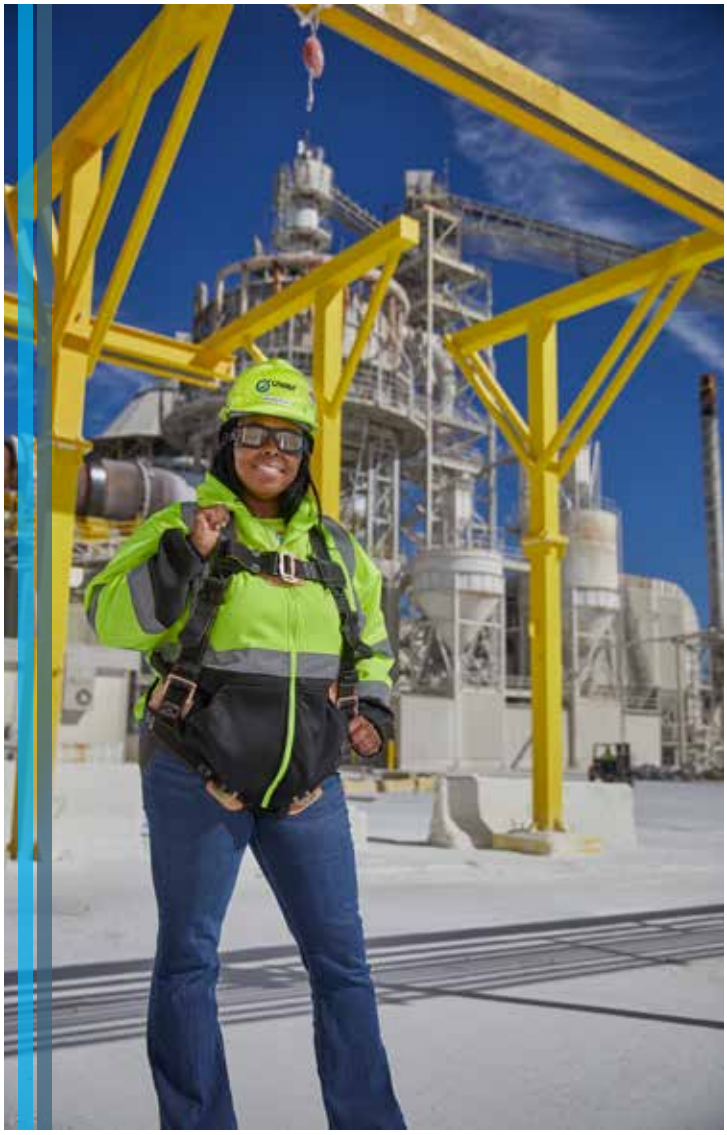
Need to Know Definitions

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount you pay for healthcare services received, as determined by your insurance plan.

Deductible – The amount you owe for healthcare services before your insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.



Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," so funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or rollover into the next plan year.

- **Healthcare FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. You must be enrolled in a PPO plan to open a Healthcare FSA account. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.
- **Limited Purpose FSA –** Designed to complement a Health Savings Account, a Limited Use FSA allows for reimbursement of eligible dental and vision expenses.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Savings Account (HSA) – A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in an HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable if you change jobs.

High Deductible Health Plan (HDHP) – A plan option that provides choice, flexibility, and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, and all qualified employee-paid medical expenses count toward your deductible and out-of-pocket maximum.

Network – A group of physicians, hospitals, and healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network –** Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network –** Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating –** Providers that have declined entering into a contract with your insurance provider. They may not accept any insurance and you could pay for all costs out-of-pocket.

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage.

Out-of-Pocket Maximum – The most you pay during the plan year before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, out-of-network provider charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred, or specialty.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs –** Prescription medications used to treat complex, chronic, and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered.
- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy –** The goal of a Step Therapy Program is to steer employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount. Also known as the UCR (Usual, Customary, and Reasonable) amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, you are provided with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) – The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Ready to Enroll?

Lhoist North America covers a significant amount of your benefit costs. Your contributions for medical, dental, and vision benefits are deducted on a pre-tax basis, lessening your tax liability. Employee contributions vary depending on the level of coverage you select — typically, the more coverage you have, the higher your portion.

Action Items

Adding Dependents.

If you are adding dependents, please make sure you have their full name, date of birth, and social security number along with any supporting documents to verify dependent relationship.

Double-check covered medications.

The medical plan you select will affect the cost of your prescriptions.

Review available plans' deductibles.

Foresee a lot of medical needs? You might want a lower deductible. If not, you could switch to a higher deductible plan and enjoy lower premiums.

Consider your HSA or FSA.

An HSA or FSA can help cover healthcare costs, including dental and vision services and prescriptions. Adding one of these accounts to your benefits can help with your long-term financial goals.

Check your networks.

Going in-network often saves you money. Check for any plan changes to make sure your go-to providers and pharmacy are still your best bet.

Now's the Time to Enroll!

Your New Hire or Annual Enrollment is the time to make benefit selections that meet your family's benefits needs.

To make changes during the current year, you will need to have a Qualifying Life Event.

What are Qualifying Life Events?

You can update your benefits when you start a new job or during Open Enrollment. But changes in your life called Qualifying Life Events (QLEs) determined by the IRS can allow you to enroll in health insurance or make changes outside of these times.

When a Qualifying Life Event occurs, you have 30 days after the date of the event to request changes to your coverage and provide supporting documents. Your change in coverage must be consistent with your change in status. Employees should go into Workday, click Menu and then Benefits. Navigate to Changing Your Benefits.

Common qualifying events include:

- A change in the number of dependents (through birth or adoption or if a child is no longer an eligible dependent)
- A change in a spouse's employment status (resulting in a loss or gain of coverage)
- A change in your legal marital status (marriage, divorce, or legal separation)
- A change in employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility
- Eligibility for coverage through the Marketplace
- Changes in address or location that may affect coverage
- Entitlement to Medicare or Medicaid

Some lesser-known qualifying events are:

- Turning 26 and losing coverage through a parent's plan
- Death in the family (leading to change in dependents or loss of coverage)
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)

Reach out to Lhoist North America's Benefits Team with questions regarding specific life events and your ability to request changes. Don't miss out on a chance to update your benefits! LNA.Benefits@lhoist.com or 800-286-0134.

Wellness

It's never too late to better your wellness. Lhoist North America is here to help with GO Wellbeing, formerly known as Well onTarget. This health-management benefit is included for all eligible employees and is completely confidential.

GO Wellbeing is LNA's wellness program. This program will provide all of us with an opportunity to receive health improvement information and participate in health promotion activities. The goal of this and future wellness programs is to encourage employees and their families to make smart healthcare decisions. GO Wellbeing will consist of educational information, tools, and activities from Blue Cross Blue Shield's GO Wellbeing wellness platform and the LNA Benefits Team.

Wellness Incentive

Preventive care is essential to your health. To encourage this, Lhoist North America provides a premium incentive when you complete an annual physical with a primary care physician (PCP). You may complete your annual physical in person with your PCP or virtually via Teladoc. The Teladoc virtual option can be accessed at teladoc.com/bcbstx or 800-835-2362. Your individual results are confidential. Lhoist North America does not have access to this private health information.

As a new hire, you will receive the wellness incentive for the current plan year. In order to receive the wellness incentive for the following year, you must complete the wellness requirements moving forward.

To earn the Wellness Incentive, $600 per year, you must complete an annual physical with your PCP either in person or virtually via Teladoc.

If you complete an annual physical, you will receive the biweekly wellness incentive on your paycheck. You could also be eligible for other incentives.

Employees who are unable to meet the requirements for this wellness incentive might qualify for an alternate opportunity (or their physician may recommend one) that would allow them to qualify for the reduced medical premium. Contact the LNA Benefits Team at 800-286-0134 to discuss alternatives.

Privacy Reminder: Lhoist North America does not have access to individual health information. The Lhoist North America statistics referenced in this communication are aggregate. Personal health information is always treated privately.

Tobacco User Surcharge

Quitting is more than an ending — it's a fresh start! We want to support your quitting journey and save you money. Lhoist North America has a tobacco user surcharge to help control employee medical premium costs. To avoid the 2027 tobacco surcharge of $600 per year, you must complete the tobacco affidavit in Workday during the annual benefits open enrollment period. If you are a tobacco user, you can still avoid the surcharge by completing the Tobacco Cessation program offered through BCBS.

Notice Regarding Wellness Program

GO Wellbeing is a voluntary wellness program available to all medical-enrolled employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve participant health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. You may also be asked to complete a biometric screening or annual preventive exam, which may include a blood test for total cholesterol, HDL, LDL, triglycerides, glucose, and cotinine screening. Your blood pressure, height, weight, and waist circumference may also be measured. You are not required to participate in the blood test or other medical examinations.

Details about the wellness and/or tobacco program, including criteria and incentives, can be found in the enrollment guide.

Although you are not required to participate in the blood test or other medical examinations, only participants who do so may qualify for the wellness incentive.

Additional incentives may be available for participants who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting 800-286-0134.

The information from your blood test or other medical examinations may be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as wellness programming and content. You also are encouraged to share your results or concerns with your own doctor.

Protections From Disclosure of Medical Information

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

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. In order to provide you with services under the wellness program, your personally identifiable health information may be shared with one or more of the following: Lockton Companies, Blue Cross Blue Shield of Texas.

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact 800-286-0134.

Medical Benefits

Medical benefits are provided through Blue Cross Blue Shield of Texas (BCBSTX). Consider the physician networks, premiums, and out-of-pocket costs for each plan when choosing for you and your family. Keep in mind your choice is effective for the entire 2027 plan year unless you have a Qualifying Life Event.

Medical Premiums

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your biweekly contributions.

How to Find a Provider

Visit www.bcbstx.com or call Customer Care at 888-423-5475 for a list of BCBSTX network providers.

BCBS Health Advocacy Solutions

Insurance can be confusing. LNA believes it is important for everyone to understand their benefits so that they can make the best decision for medical care. To make this easier, LNA has purchased Health Advocacy Solutions, a concierge service from Blue Cross Blue Shield.

- Get personal assistance with your healthcare matters
- Understand your health benefits
- Talk to your BCBS TX clinician about health questions
- Sort out a new diagnosis and what to do next
- Shop for quality, lower-cost healthcare

Stop trying to do it all on your own! Your Health Advocate is here for you. Call or chat with your advocate today. Download the BCBSTX App to live chat or call 888-423-5475.

Note

Preventive care offered by an in-network physician, like well-woman exams or annual physicals, is often covered at 100%.

Urgent Care Centers vs. Freestanding Emergency Rooms

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

Telemedicine

Available through Teladoc (a partner of BCBSTX). You are able to receive physician consultation 24/7 through your smartphone or tablet. Typical consultations might be for a sinus infection, pink eye, strep throat or an ear infection. For more information, please visit teladoc.com/bcbstx or call 800-835-2362.

BCBS Wellness Programs

GO Wellbeing (effective 1/1/2027)

Rewards for healthy living! You can earn GO Points by participating and completing healthy activities through the program. Once you earn the points, you can redeem these points in the online shopping mall. You can access GO Wellbeing by logging in to your BCBSTX Member account.

Don't forget to complete the RealAge Test for 300 GO points!

Tobacco Cessation

GO Wellbeing, formerly known as Well onTarget, offers members an opportunity to be tobacco free by completing the Tobacco Cessation program. Members can learn to quit tobacco products through innovative lessons.

Livongo by Teladoc Health

Being covered with BCBSTX means you are eligible for two free benefit programs that can help you manage your health.

Diabetes - Sign up and receive a welcome kit within 3-5 days. The program offers unlimited test strips, connection to a blood glucose meter, personalized insights, and expert coaching. Visit join.livongo.com/BCBSTX/hi or call 800-945-4355 for additional information. Registration code: BCBSTX.

Hypertension - Resources are available to help you easily manage high blood pressure. The program offers technology, insights and experts to help you stay on track. You can monitor your numbers, get personalized tips after every check, receive reminders, send data directly to your doctor, and receive customized reports. Visit ready.livongo.com/TXHTN or call 800-945-4355 for additional information. Registration code: TXHTN.

Wondr Health

Now you can lose weight, gain energy, sleep better, and improve your mind and body all while eating your favorite foods. Wondr Health is a skills-based digital weight loss program that teaches you how to enjoy the foods you love to improve your overall health without having to count calories. Go to wondrhealth.com/Lhoist for additional information.

A BMI of 25 or higher is required to participate in the program.

Maven

Maven, in partnership with Blue Cross Blue Shield of Texas, is a virtual health platform to help you and your family navigate maternity and newborn care, parenting and pediatrics, menopause and midlife health, and more. Maven includes 24/7 support from a personal care team, unlimited video visits, and helpful articles, videos, and classes.

Key features include:

- Care advocates to personalize the member journey
- Expert approved resources, guidance and community groups
- 24/7 virtual appointments and messaging with providers like Reproductive Endocrinologists, OB-GYNs, doulas, lactation consultants, mental health specialists, and more
- Integration with BCBSTX Care Management includes support for high-risk maternity management, behavioral and social needs

Your membership is covered by Lhoist – sign up today at http://mavenclinic.com/join/benefit.

FlexAccess

One of your new Blue Cross and Blue Shield of Texas benefits is FlexAccess, a program that helps you find cost assistance (coupon) programs to help cover the cost of your medicine. With FlexAccess, your cost share for your medicine(s) could be reduced.

Some examples of drug therapeutic classes in the program are:

- Anti-Infective
- Autoimmune
- Bone Density
- Cystic Fibrosis
- Endocrine
- HIV
- Lung Disorders
- Multiple Sclerosis
- Pulmonary Hypertension
- Sleep Disorders

Please call 888-302-3618, Monday–Friday, 7:00am–7:00pm Central Time, to be led through the enrollment process. If you do not sign up before you fill your next prescription, you may pay up to the full price of your medicine(s).

Please contact Member Services at 888-302-3618 or by email at member.services@flexaccessrx.com if you have any questions.

Medical Plan Summary

This chart summarizes the 2027 medical coverage provided by BCBSTX. All covered services are subject to medical necessity as determined by the plan. Please note that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

REMINDER: To reduce your medical contributions costs, please remember to complete the requirements to earn the Wellness Incentive and complete the tobacco affidavit to waive the Tobacco Surcharge. Potential costs savings of $1,200 annually: $600 for the Wellness Incentive and $600 for the Tobacco Surcharge.

You must call BCBS Health Advocacy Solutions to receive approval for MRI and CT Scan imaging, or you will receive a $100 penalty fee.

	PPO	HDHP
BIWEEKLY CONTRIBUTIONS		
EMPLOYEE ONLY	$94.07	$79.05
EMPLOYEE + SPOUSE	$174.80	$142.97
EMPLOYEE + CHILD(REN)	$147.89	$120.88
EMPLOYEE + FAMILY	$248.65	$199.15

	PPO		HDHP	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE				
INDIVIDUAL	$1,500	$3,000	$3,500	$5,600
FAMILY	$3,000	$6,000	$7,000	$11,200
COINSURANCE (YOU PAY)	20%*	40%*	20%*	40%*
ANNUAL OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)				
INDIVIDUAL	$6,000	$12,000	$5,000	$10,000
FAMILY	$8,000	$16,000	$7,000	$14,000
COPAYS/COINSURANCE				
PREVENTIVE CARE	100% No Deductible	100% No Deductible	100% No Deductible	100% No Deductible
PHYSICIAN OFFICE	$30	40%*	20%*	40%*
SPECIALIST OFFICE	$60	40%*	20%*	40%*
URGENT CARE	$80	40%*	20%*	40%*
EMERGENCY ROOM	Deductible + 20%		Deductible + 20%	
TELEMEDICINE	$0	N/A	20%*	N/A
X-RAY/LAB	20%*	40%*	20%*	40%*
OUTPATIENT/INPATIENT**	20%*	40%*	20%*	40%*

*After deductible
**Blue Distinction Center Providers = 10% Coinsurance after deductible

With both the PPO and the HDHP, the individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will also be applied toward the "per family" deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the "per family" deductible amount. The same typically applies for the out-of-pocket maximum.

Healthcare Cost Transparency

There are so many different providers and varying costs for healthcare services — how do you choose? Online services called healthcare cost transparency tools can help. Available through most health insurance carriers, these tools allow you to compare costs for services, from prescriptions to major surgeries, to make your choices simpler. Visit www.bcbstx.com to learn more.

Out-of-Pocket Costs

These are the types of payments you're responsible for:

Copay

The fixed amount you pay for healthcare services at the time you receive them.

Deductible

The amount you must pay for covered services before your insurance begins paying its portion/coinsurance.

Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

Coinsurance

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.

How to Pick a Plan

What plan is right for you? Consider any medical needs you foresee for the upcoming plan year, your overall health, and any medications you currently take. Keep in mind that the annual out-of-pocket maximum is higher on the PPO than the HDHP.

How does a PPO (Preferred Provider Organization) work?

- You'll pay more in premiums, but perhaps less at the time of service.
- You can choose from a network of providers who offer a fixed copay for services.
- If you expect to need more medical care this year or you have a chronic illness, the PPO may be the right choice for you to ensure your healthcare needs are covered.

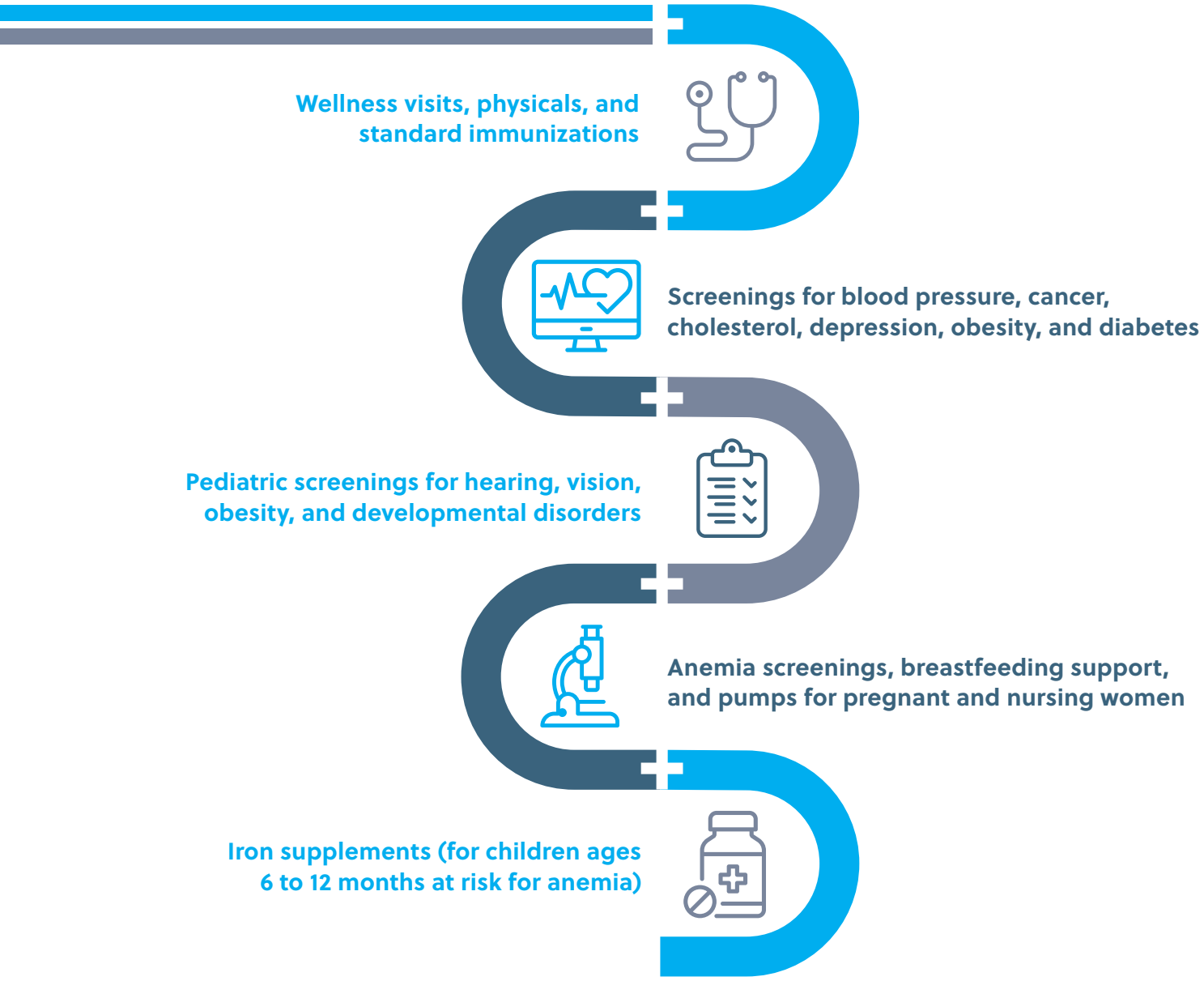
How does an HDHP (High Deductible Health Plan) work?

- You'll pay less in premiums. (Think less money from your paycheck.)
- You'll pay for the full cost of non-preventive medical services until you reach your deductible.
- You may also use your Health Savings Account (HSA) to pay for Healthcare expenses.
- If you expect to mostly use preventive care (which is covered), this plan could be for you.

Preventive Care

Routine checkups and screenings are considered preventive, so they're often paid at 100% by your insurance.

Keep up to date with your primary care physician to stay on top of your overall health. Under the U.S. Patient Protection and Affordable Care Act (PPACA), some common covered services include:



Don't miss out on these covered services. But remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. So, if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

Where to Go for Care

You're feeling sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new prescription, but the pharmacy is closed. Instead of rushing to the emergency room or relying on questionable information from the internet, consider all of your site-of-care options.

Nurse Line

When to Use

You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.

Types of Care*

Answers to questions regarding:

- Symptoms
- Self-care/home treatments
- Medications and side effects
- When to seek care

Costs and Time Considerations**

- Usually available 24 hours a day, 7 days a week
- Typically free as part of your medical insurance

Telemedicine

When to Use

You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

Types of Care*

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems

Costs and Time Considerations**

- Usually a first-time consultation fee and a flat fee or copay for any visit thereafter
- Usually immediate access to care
- Prescriptions through telemedicine or virtual visits not allowed in all states

Primary Care Center

When to Use

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

Types of Care*

- Routine checkups
- Immunizations
- Preventive services
- Manage your general health

Costs and Time Considerations**

- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Virtual Primary Care also available through Teladoc
- Usually little wait time with scheduled appointment

Urgent Care Center

When to Use

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

Types of Care*

- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
- X-rays

Costs and Time Considerations**

- Often requires a copay and/or coinsurance usually higher than an office visit
- Walk-in patients welcome, but waiting periods may be longer (urgency decides order)

Do Your Homework

What may seem like an urgent care center could actually be a standalone ER. These facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

Emergency Room

When to Use

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

Types of Care*

- Heavy bleeding
- Chest pain
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

Costs and Time Considerations**

- Often requires a much higher copay and/or coinsurance
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first
- Ambulance charges, if applicable, will be separate and may not be in-network

*This is a sample list of services and may not be all inclusive.

**Costs and time information represent averages only and are not tied to a specific condition or treatment.

Pharmacy Benefits

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through BCBSTX. That means you will only have one ID card for both medical care and prescriptions. Information on your benefits coverage and a list of network pharmacies is available online at www.bcbstx.com or by calling the Health Advocate number on your ID card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Preferred, Non-Preferred, or Specialty.

Generic Drugs

Want to save money on meds? Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety, and strength. Because they are the same medicine, generic drugs are just as effective as the brand names, and they undergo the same rigid FDA standards. **But generic versions cost 80% to 85% less on average than the brand-name equivalent.** To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

Note: Apps like GoodRx and RxSaver let you compare prices of prescription drugs and find possible discounts. Make sure to check the price against the cost through your insurance to get the best deal. Note that these discounts can't be combined with your benefit plan's coverage. So if you choose to use a discount card from an app such as GoodRx or RxSaver, the amount you pay will not count toward your deductible or out-of-pocket maximum under the benefit plan.

Are your prescription medicines covered?

With your BCBSTX plan, your drug list is called Topaz. When you use a drug on your drug list, your copay/insurance (what you pay out-of-pocket) will usually be lower. You can still fill prescriptions for drugs that are not on your drug list, but you will pay more.

How to find a drug on the drug list that's right for you:

1. Visit MyPrime.com and sign in — or register if you don't already have an account.
2. Select Find Medicines to see if your medicine is covered.
3. If your medicine isn't covered, talk to your doctor about therapeutic alternatives. Your doctor can also request a coverage exception from BCBSTX (unless you have a benefit exclusion).

If you have questions about your pharmacy benefit, please call the toll-free number listed on your member ID card.

	PPO		HDHP	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
RETAIL RX (30-DAY SUPPLY)				
PREVENTIVE DRUGS				
GENERIC	$10	Copay + 40%	$10	40%*
PREFERRED BRAND	$50	Copay + 40%	$50	40%*
NON-PREFERRED BRAND	$100	Copay + 40%	$100	40%*
SPECIALTY	$150	Copay + 40%	$150	40%*
NON-PREVENTIVE DRUGS				
GENERIC - NON PREVENTIVE	$10	Copay + 40%	20%*	40%*
PREFERRED BRAND	$50	Copay + 40%	20%*	40%*
NON-PREFERRED BRAND	$100	Copay + 40%	20%*	40%*
SPECIALTY	$150	Copay + 40%	20%*	40%*
MAIL ORDER RX (90-DAY SUPPLY)				
PREVENTIVE DRUGS				
GENERIC	$20	Copay + 40%	$20	40%*
PREFERRED BRAND	$100	Copay + 40%	$100	40%*
NON-PREFERRED BRAND	$200	Copay + 40%	$200	40%*
SPECIALTY	$300	Copay + 40%	$300	40%*
NON-PREVENTIVE DRUGS				
GENERIC - NON-PREVENTIVE	$20	Copay + 40%	20%*	40%*
PREFERRED BRAND	$100	Copay + 40%	20%*	40%*
NON-PREFERRED BRAND	$200	Copay + 40%	20%*	40%*
SPECIALTY	$300	Copay + 40%	20%*	40%*

*After deductible

Preventive Drugs

Affordable Care Act (ACA) preventive drugs are covered at 100%. Call the BCBS Health Advocate to find out what drugs are covered at 100%.

FSA vs HSA

Flexible Spending Accounts		Health Savings Accounts
Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.	OWNERSHIP	You own your HSA. It is a savings account in your name, and you always have access to the funds, even if you change jobs.
You can elect a Healthcare FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You cannot be enrolled in both a Healthcare FSA and an HSA.	ELIGIBILITY & ENROLLMENT	You must be enrolled in a Qualified HDHP to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or a spouse's FSA or enrolled in Medicare or TRICARE. You can change your contribution at any time during the Plan Year.
FSA contributions are tax-free via payroll deduction. Funds are spent tax-free when used for qualified expenses.	TAXATION	HSA contributions are tax-free; the account grows tax-free; and funds are spent tax-free on qualified expenses.
Participating employees can contribute up to the IRS limit. The 2026 FSA contribution maximum was $3,400. The IRS has not yet announced the 2027 limit. This amount may be increased annually.	CONTRIBUTIONS	Both you and your employer can contribute up to $4,500 in 2027 (up to $9,000 for families). Ages 55+ can make an annual $1,000 "catch-up" HSA contribution.
Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit receipts for reimbursement.	PAYMENT	Many HSAs include a debit card to pay for qualified expenses directly. Alternatively, you can save funds for future expenses or retirement.
Any unclaimed funds at the end of the year are forfeited. Exceptions might include an additional 2.5-month grace period for expenses to be incurred and reimbursed, or an allowed rollover amount.	ROLLOVER OR GRACE PERIOD	HSA funds roll over from year to year. The account is portable and may be used for future qualified expenses — even in retirement years.
Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, and vision care. A full list is available at www.irs.gov.	QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full list is available at www.irs.gov.
Dependent Care FSA (pre-tax dollars can be used for elder or child dependent care) and Limited Use FSA (used to pay for eligible dental and vision expenses).	OTHER TYPES	N/A

Health Savings Account

Want funds handy to help cover out-of-pocket healthcare expenses? A Health Savings Account (HSA) is a personal healthcare bank account used to pay for qualified medical expenses. HSA contributions and withdrawals for qualified healthcare expenses are tax-free. You must be enrolled in an HDHP to participate.

HSA Bank will issue you a debit card with direct access to your account balance. Use your debit card to pay for qualified medical expenses — no need to submit receipts for reimbursement. Like a regular debit card, you must have a balance in your HSA account to use the card.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, PPE, over-the-counter medications, and more. Visit IRS Publication 502 on www.irs.gov for a complete list.

Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in an HSA-eligible High Deductible Health Plan.
- You are not covered by your spouse's or parent's non-HDHP.
- You or your spouse does not have a Healthcare Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

Pre-tax Paycheck Contributions

Employer Contributions
(pre-tax)

HSA

Tax-free Payments
(for qualified medical expenses)

Unused funds roll over annually

Note

Because HSA funds never expire, contributing your annual maximum to your HSA can help you save to pay for healthcare expenses tax-free after retirement.

You Own Your HSA

Your HSA is a personal bank account that you own and manage. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change plans or jobs. There are no vesting requirements (you own all contributed HSA funds immediately) or forfeiture provisions (you keep all HSA funds whether you leave the company or retire).

How to Enroll

To enroll in Lhoist North America's HSA, you must elect the HDHP with Lhoist North America. Submit all HSA enrollment materials and choose the amount to contribute on a pre-tax basis. Lhoist North America will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

HSAs and Taxes

HSA contributions are made through payroll deduction on a pre-tax basis when you open an account with HSA Bank. The money in your HSA (including interest and investment earnings) grows tax-free. When the funds are used for qualified medical expenses, they are spent tax-free.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax. This is why it's important to know what medical expenses qualify for HSA use and to keep track of where you spend your HSA funds.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2027, contributions (which include any employer contribution) are limited to the following:

ANNUAL HSA FUNDING LIMITS	
EMPLOYEE	$4,500
FAMILY	$9,000
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

LNA funds an HSA contribution by January 15 to participating employees. New Hires will receive a prorated contribution based on hire date.

ANNUAL EMPLOYER HSA CONTRIBUTION	
EMPLOYEE	$550
FAMILY	$1,100

HSA contributions over the IRS annual contribution limits ($4,500 for individual coverage and $9,000 for family coverage for 2027) are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you have two options:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed.
- Leave the excess contributions in your HSA and pay 6% excise tax on them. Next year consider contributing less than the annual limit to your HSA.

The Lhoist North America HSA is established with HSA Bank. You may be able to roll over funds from another HSA. For more enrollment information, contact the LNA Benefits Team or visit www.hsabank.com.

Flexible Spending Accounts

Take control of your spending! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses.

Healthcare Flexible Spending Account

You can contribute up to the annual IRS maximum for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them — no waiting for reimbursement. Please also refer to www.irs.gov for the annual FSA contribution limits.

- Up to $680* of unused funds may be rolled over to the following year to use.

Limited Purpose Flexible Spending Account

A Limited Purpose Flexible Spending Account works with a Health Savings Account (HSA) and allows for reimbursement of eligible dental and vision expenses. Please also refer to www.irs.gov for the annual FSA contribution limits.

- Up to $680* of unused funds may be rolled over to the following year to use.

*The IRS has not yet announced the 2027 limit. This amount may be increased annually.

Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — even if you don't elect any other benefits. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is currently deposited in your account.

- With the Dependent Care FSA, you can set aside up to $7,500 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- Expenses are reimbursable if the provider is not your dependent.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent daycare expenses that are necessary for you and your spouse to work or attend school full time. Eligible expenses include:

- In-home babysitting services (not provided by a dependent)
- Care of a preschool child by a licensed nursery or daycare provider
- Before- and after-school care
- Day camp
- In-house dependent daycare

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

Using the Account

Use your FSA debit card at doctor and dentist offices, pharmacies, and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you use the card at an ineligible location.

If you do not use your FSA debit card, you may submit a claim form along with the required documentation. Contact Navia Benefit Solutions with reimbursement questions. If you need to submit a receipt, Navia Benefit Solutions will notify you. Always save receipts for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. Without proof an expense was valid, your card could be turned off and the expense deemed taxable.

General Rules

The IRS has the following rules for Healthcare and Dependent Care FSAs:

- Expenses must occur during the 2027 plan year.
- Funds cannot be transferred between FSAs.
- You cannot participate in a Dependent Care FSA and claim a dependent care tax deduction at the same time.
- You must "use it or lose it" — any unused funds will be forfeited.
- Up to $680* may be rolled over to the next plan year at the end of 2027 for Healthcare or Limited Use FSAs.
- You cannot change your FSA election in the middle of the plan year without a Qualifying Life Event.
- You have ninety (90) days following the end of the plan year to submit eligible FSA claims for reimbursement.
- Those considered highly compensated employees may have different FSA contribution limits. Visit www.irs.gov for more info.

*The IRS has not yet announced the 2027 limit. This amount may be increased annually.

Note

You can use your FSA funds to pay for deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, and more.

Dental Benefits

Like brushing and flossing, visiting your dentist is an essential part of your oral health. Lhoist North America offers affordable plan options from Delta Dental for routine care and beyond.

Stay In-Network

If your dentist doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit Delta Dental at www.deltadentalins.com.

Dental Premiums

Dental premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your biweekly premium.

	PPO	
BIWEEKLY CONTRIBUTIONS		
EMPLOYEE ONLY	$3.52	
EMPLOYEE + SPOUSE	$7.43	
EMPLOYEE + CHILD(REN)	$6.02	
EMPLOYEE + FAMILY	$11.04	
	IN-NETWORK	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE		
INDIVIDUAL	$50	$50
FAMILY	$150	$150
ANNUAL MAXIMUM		
PER PERSON	$2,000	$2,000
COVERED SERVICES		
PREVENTIVE SERVICES	100%	100%
BASIC SERVICES	80%*	80%*
MAJOR SERVICES	50%*	50%*
ORTHODONTICS Dependent Child(ren) Only – Up to Age 20	50%	50%
ORTHODONTIC LIFETIME MAXIMUM	$2,000	$2,000

*After deductible

Note

Oral health is linked to your overall health — keeping your mouth healthy can protect you from cardiovascular disease, pregnancy complications, and pneumonia.

Vision Benefits

Getting your eyes checked regularly is important even if you don't wear glasses or contacts. We provide quality vision care for you and your family through VSP.

Vision Premiums

Vision premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your biweekly premium.

Vision Plan Summary

VSP LightCare is available for both Enhanced Advantage Plans. With VSP LightCare, you can use your frame and lens benefit to get non-prescription eyewear from your VSP network doctor.

Each covered member receives an additional pair of eyewear per year. This means two frames, two contacts, OR one frame and one contacts.

	ENHANCED ADVANTAGE BASE PLAN			ENHANCED ADVANTAGE BUY-UP PLAN		
BIWEEKLY CONTRIBUTIONS						
EMPLOYEE ONLY	$0.97			$2.14		
EMPLOYEE + SPOUSE	$1.95			$3.73		
EMPLOYEE + CHILD(REN)	$2.09			$3.99		
EMPLOYEE + FAMILY	$3.34			$6.37		
	IN-NETWORK	**OUT-OF-NETWORK**	**FREQUENCY**	**IN-NETWORK**	**OUT-OF-NETWORK**	**FREQUENCY**
EXAMS						
COPAY	$10	Up to $50	Calendar year	$10	Up to $50	Calendar year
LENSES						
SINGLE VISION	$10	Up to $50	Calendar year	$10	Up to $50	Calendar year
BIFOCAL		Up to $75		$10	Up to $75	
TRIFOCAL		Up to $100		$10	Up to $100	
PROGRESSIVE**		Up to $75		$50	Up to $75	
FRAMES						
COPAY	$150 allowance, 20% off balance	Up to $70	Calendar year	$150 allowance, 20% off balance	Up to $70	Calendar year
CONTACTS*						
MEDICALLY NECESSARY	$150 allowance for contacts; 15% off contact lens exam, not to exceed $60	Up to $105	Calendar year	$150 allowance for contacts; 15% off contact lens exam, not to exceed $60	Up to $105	Calendar year

*Fitting and Evaluation fee applied to contact lens allowance
**Enhanced Advantage Base Plan covers Standard Progressive lenses only. Enhanced Advantage Buy-Up Plan covers all Progressive lenses.

Note

Early detection of vision conditions like diabetic retinopathy leads to more effective treatment and cost savings.

Survivor Benefits

It's hard to think about, but it's important to have a plan in place to provide for your family if something were to happen to you. Survivor benefits provide financial protection in the event of an unexpected event.

Basic Life and Accidental Death & Dismemberment Insurance

Lhoist North America provides employees with Basic Life and Accidental Death and Dismemberment (AD&D) insurance as part of your basic coverage through Reliance Matrix, which provides financial protection to your spouse or other designated survivor(s) in the event of your passing or the loss of a limb.

Your Basic Life and AD&D insurance benefit is 2x annual base pay, up to a maximum of $1,500,000. If you are a full-time employee, you automatically receive Life and AD&D insurance even if you waive other coverage.

Naming a Beneficiary

Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life. Reliance Matrix Insurance is managing Basic Life and AD&D insurance benefit claims.

Name a primary and contingent beneficiary to make your intentions clear. Indicate their full name, address, Social Security number, relationship, date of birth, and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches age 18. Contact the LNA Benefits Team or your own legal counsel with any questions.

Voluntary Life and AD&D Insurance

You may wish for extra coverage for more peace of mind. Eligible employees may purchase additional Voluntary Life and AD&D insurance. Premiums are paid through payroll deductions.

BASIC EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	2x annual base pay
WHO PAYS	Lhoist North America
BENEFITS PAYABLE	If you die, lose a limb, or suffer paralysis in an accident while covered under the Plan.
MAXIMUM BENEFIT	2x annual base pay to a maximum of $1,500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
VOLUNTARY EMPLOYEE LIFE	
COVERAGE AMOUNT	1 to 4 times your annual base pay to a maximum of $1,500,000 combined with your Basic Term Life coverage amount.
WHO PAYS	This coverage is available to you on a voluntary basis. You pay full cost.
BENEFITS PAYABLE	If you die while covered under the Plan.
MAXIMUM BENEFIT	$1,500,000 combined with your Basic Term Life coverage amount.
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Evidence of Insurability is required. **New Hires:** Eligible to elect $300,000 without answering medical questions if enrolling when first eligible. Amounts over $300,000 will require completion of EOI. **Current Participants:** During Annual Enrollment you may increase current coverage amount by 1 times your covered annual earnings, up to a total coverage amount of $300,000 without answering medical questions. Any Increase above 1x your covered earnings and/or $300,000 will require EOI.
VOLUNTARY SPOUSE LIFE	
COVERAGE AMOUNT	$20,000, $50,000 or $75,000
WHO PAYS	This coverage is available to you on a voluntary basis. You pay full cost.
BENEFITS PAYABLE	If your spouse dies while covered under the Plan.
MAXIMUM BENEFIT	$75,000, not to exceed 100% of your combined Optional Term. You must elect at least 1x covered earnings for yourself to purchase coverage for your spouse.
EVIDENCE OF INSURABILITY (EOI) REQUIRED	**New Hires:** EOI is required for coverage amounts over $20,000. **Current Employees:** EOI is required for all coverage amounts.
VOLUNTARY CHILD LIFE	
COVERAGE AMOUNT	$10,000
WHO PAYS	This coverage is available to you on a voluntary basis. You pay full cost.
BENEFITS PAYABLE	If your child dies while covered under the Plan.
MAXIMUM BENEFIT	$10,000. You must elect at least 1x covered earnings for yourself to purchase coverage for your dependents.
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
VOLUNTARY EMPLOYEE AD&D	
COVERAGE AMOUNT	1 - 4x annual base pay
WHO PAYS	This coverage is available to you on a voluntary basis. You pay full cost.
BENEFITS PAYABLE	If you die, lose a limb, or suffer from paralysis in an accident while covered under the Plan.
MAXIMUM BENEFIT	$1,500,000 combined with your Basic AD&D amount.
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
VOLUNTARY SPOUSE AD&D	
COVERAGE AMOUNT	$20,000, $50,000 or $75,000
WHO PAYS	This coverage is available to you on a voluntary basis. You pay full cost.
BENEFITS PAYABLE	If your spouse dies, loses a limb, or suffers from paralysis in an accident while covered under the Plan.
MAXIMUM BENEFIT	$75,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
VOLUNTARY CHILD AD&D	
COVERAGE AMOUNT	$10,000
WHO PAYS	This coverage is available to you on a voluntary basis. You pay full cost.
BENEFITS PAYABLE	If your child dies, loses a limb, or suffers from paralysis in an accident while covered under the Plan.
MAXIMUM BENEFIT	$10,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No

VOLUNTARY EMPLOYEE LIFE INSURANCE	
PREMIUM RATES/$1,000 (MONTHLY)	
AGE (AS OF JANUARY 1, 2027)	EMPLOYEE
0-29	$0.070
30-34	$0.080
35-39	$0.097
40-44	$0.150
45-49	$0.246
50-54	$0.414
55-59	$0.642
60-64	$1.000
65-69	$1.808
70+	$2.060

VOLUNTARY SPOUSE LIFE INSURANCE	
PREMIUM RATES/MONTH	
COVERAGE	SPOUSE RATE
$20,000	$3.016
$50,000	$8.880
$75,000	$13.320

VOLUNTARY AD&D INSURANCE
PREMIUM RATES / $1,000 (MONTHLY)
$0.048

VOLUNTARY CHILD LIFE INSURANCE
PREMIUM RATES / $10,000 (MONTHLY)
$1.128

The examples below illustrate how voluntary Life and AD&D insurance premiums are calculated based on age, coverage elections, and family status. Actual costs will vary depending on the coverage amounts selected.

Example 1: Family Coverage

Amanda (41 years old), married with one child, earns $50,000 annually and elects additional Life and AD&D coverage for her family. What would her monthly cost be?

1. Employee Life (3x annual pay = $150,000)
   - Premium: 150 × $0.150 = $22.50/month
2. Employee AD&D (2x annual pay = $100,000)
   - Premium: 100 × $0.048 = $4.80/month
3. Spouse Life & AD&D ($50,000 each)
   - Premium: $11.28/month
4. Child Life & AD&D ($10,000)
   - Premium: $1.61/month

Total Monthly Cost: $40.19

Example 2: Planning for Retirement Years

Michael (58 years old), married, earns $50,000 annually and elects additional coverage for himself and his spouse as he plans for retirement. What would his monthly cost be?

1. Employee Life (2x annual pay = $100,000)
   - Premium: 100 × $0.642 = $64.20/month
2. Employee AD&D (1x annual pay = $50,000)
   - Premium: 50 × $0.048 = $2.40/month
3. Spouse Life ($20,000)
   - Premium: $3.02/month

Total Monthly Cost: $69.62

Income Protection

You and your loved ones depend on your regular income. That's why Lhoist North America offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury. A portion of your income is protected until you can return to work or you reach retirement age.

Basic Long-Term Disability (LTD) Insurance

Long-Term Disability (LTD) benefits are available at no cost. This insurance replaces 60% of your income if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents for details.

MONTHLY MAXIMUM BENEFIT	$10,000
ELIMINATION PERIOD	90 days
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

Long-Term Disability Buy-Up Insurance

You may supplement the Basic LTD that is provided with the LTD Buy-Up to receive 66.67% of your income. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents for details.

MONTHLY MAXIMUM BENEFIT	$10,000
ELIMINATION PERIOD	90 days
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

Please note: If your base salary is $400,000 or above, you will not be eligible to purchase the LTD Buy-Up. Evidence of Insurability (EOI) is required for enrollment.

Note

Around 30% of Americans ages 35-65 will suffer a disability lasting at least 90 days during their careers. (Source: Million Dollar Round Table)

Unum Supplemental Health Benefits

Lhoist North America offers several ways to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Existing policy holders may call 1-800-635-5597 for service-related issues.

Accident Coverage

Accident coverage through Unum provides benefits for you and your covered family member for expenses related to an accidental injury that occurs outside of work. Health insurance helps with medical expenses, but this coverage is an additional layer of protection that can help pay deductibles, copays and coinsurance.

Plan Highlights

- Employee must purchase coverage for themselves in order for their spouse and child to be covered.
- You're guaranteed base coverage without answering health questions.
- You can keep your coverage if you change jobs or retire. You will be billed directly to your home.
- Be Well Benefit. Receive $50 every year for getting a covered Be Well screening test.

BIWEEKLY CONTRIBUTIONS	
EMPLOYEE ONLY	$5.18
EMPLOYEE + SPOUSE	$9.56
EMPLOYEE + CHILD(REN)	$11.70
FAMILY	$16.07

ACCIDENT COVERAGE

SUMMARY OF BENEFITS*	
FRACTURES	$225-$4,500
DISLOCATIONS	$150-$3,375
EMERGENCY ROOM TREATMENT	$300
TRANSFUSIONS	$400
PHYSICIAN FOLLOW-UP VISIT	$100
THERAPY SERVICES	$50
HOSPITAL OR ICU BENEFIT	$1,000
BURNS (2ND AND 3RD DEGREE)	$500-$10,000
CONCUSSION	$200
KNEE CARTILAGE (MENISCUS) WITH REPAIR	$750
DURABLE MEDICAL EQUIPMENT	$50-$200
AMBULANCE	$500-$1,500
PROSTHETIC DEVICE	$750-$1,500

*This list is a summary. Refer to plan documents for a comprehensive list of covered benefits.

Critical Illness Coverage

Critical Illness coverage through Unum pays a lump-sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like. Examples include helping pay for expenses not covered by your medical plan, lost wages, childcare, travel, home healthcare costs, or any of your regular household expenses. Premiums are based on the employee's age on the effective date of coverage. Even if the spouse is in a different age band, the rates are based on the employee's age. Children are covered at no additional cost when you elect employee coverage.

Plan Highlights

- Employee must purchase coverage for themselves in order to purchase spouse or child (up to age 26) coverage.
- Employee - choose from $10,000 to $30,000 in increments of $5,000.
- Spouses - receive 100% of the employee coverage amount.
- Children - their coverage amount is 100% of your coverage amount.
- Coverage is portable. You may take the coverage with you if you leave the company or retire. You will be billed directly to your home.

BIWEEKLY RATES PER $5,000 OF COVERAGE		
AGE	EMPLOYEE ONLY	EMPLOYEE + SPOUSE
<25	$0.42	$0.84
25-29	$0.58	$1.16
30-34	$0.85	$1.70
35-39	$1.11	$2.22
40-44	$1.68	$3.36
45-49	$2.63	$5.26
50-54	$4.25	$8.50
55-59	$6.18	$12.36
60-64	$9.12	$18.24
65-69	$13.68	$27.36
70-74	$20.56	$41.12
75-79	$20.56	$41.12

CALCULATE YOUR COST CHOOSE THE RATE FOR YOUR CURRENT AGE:				
$	÷ 5,000	X	=	$
Amount of coverage you want		Rate		

Covered Benefits

CRITICAL ILLNESS	
A Heart Attack Stroke Major organ failure End-stage kidney failure	Coronary artery disease Major (50%): Coronary artery bypass graft or valve replacement Minor (10%): Balloon angioplasty or stent placement
CANCER CONDITIONS	
Invasive cancer - all breast cancer is considered invasive	Non-invasive cancer (25%) Skin cancer - $500
PROGRESSIVE DISEASES	**SUPPLEMENTAL CONDITION**
Amyotrophic Lateral Sclerosis (ALS) Dementia, including Alzheimer's disease Multiple Sclerosis (MS) Parkinson's disease Functional loss	Loss of sight, hearing, or speech Benign brain tumor Coma Permanent paralysis Occupational HIV, Hepatitis B, C,or D Infectious Diseases (25%)

Unum's Hospital Indemnity Plan

Hospital Indemnity Plan

Hospital Insurance coverage through Unum pays cash benefits directly to you if you are admitted to the hospital for a covered accident, illness or childbirth. The money can help you pay the out-of-pocket medical expenses your medical plan may not cover.

Plan Highlights

- The money is paid directly to you — not to a hospital or care provider.
- Employee must purchase coverage for themselves in order to purchase spouse or child (up to age 26) coverage.
- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire, without having to answer new health questions. You will be billed directly from Unum.

Be Well Benefit

- Every year, each family member who has Hospital coverage can also receive $50 for getting a covered Be Well screening test such as annual exams, wellchild visits, dental, and vision exams, preventive gender specific screenings, immunizations, etc.

HOSPITAL	BENEFITS	
HOSPITAL ADMISSION	Payable for a maximum of 1 day per year	$1,000
ICU ADMISSION	Payable for a maximum of 1 day per year	$1,000
HOSPITAL DAILY STAY	Payable per day up to 365 days	$200
ICU DAILY STAY	Payable per day up to 30 days	$200
ADDITIONAL INPATIENT CARE	**BENEFITS**	
MENTAL/NERVOUS OR SUBSTANCE ABUSE TREATMENT	Payable for a maximum of 1 day per insured per calendar year	$250

BIWEEKLY CONTRIBUTIONS	
EMPLOYEE ONLY	$8.41
EMPLOYEE + SPOUSE	$20.15
EMPLOYEE + CHILD(REN)	$12.41
FAMILY	$24.15

Retirement Planning

No matter where you are in your career or what age you are, you should take advantage of the savings opportunities in the company's 401(k) plan.

Contributing to your own 401(k) account can help you feel more financially secure later in life. The Lhoist North America 401(k) plan provides you with the tools you need to prepare.

PLAN AT A GLANCE	
PLAN NAME	Lhoist North America 401(k) Plan
RECORDKEEPER	T. Rowe Price
WEBSITE	rps.troweprice.com
ELIGIBILITY	On your day of hire
COMPANY MATCH	Lhoist North America offers a safe harbor match. We will match 100% of the first 3% you contribute to the Plan and 50% of the next 2% (a total of 4%). You are 100% vested in the company match as soon as you contribute.

When Am I Enrolled?

You will be automatically enrolled into the 401(k) Plan within 30 days from your date of hire. The default contribution rate will be 5% Pre-Tax and the investment will placed in an age-based T. Rowe Price Retirement Trust based on the year you'll turn age 65.

During the 30-day window, you can change your contribution rate, contribution type, investment election, or choose to OPT OUT of the plan completely before your first contribution is deducted from your paycheck.

Name your beneficiary! Please add your beneficiary information to ensure your 401(k) savings are distributed according to your wishes.

Contributing to the Plan

2026 CONTRIBUTIONS*	
DEFERRED CONTRIBUTION LIMIT	$24,500*
CATCH-UP LIMIT (AGE 50+)	$8,000*
HIGHER CATCH-UP LIMIT (AGES 60-63)	$11,250*

*IRS has not yet announced 2027 contribution limits. Limits shown reflect current IRS limits and are subject to change.

Not sure if you're getting close to the annual contribution limit? Our payroll system tracks how much you've contributed. If you started at the company mid-year, let the Payroll Department know how much you contributed at your previous employer so that can be factored in and you won't be subject to penalties for overcontributing.

How Much Should I Save?

Industry standards suggest saving at least 12% to 15% of your income, including Lhoist North America's generous matching contribution of 100% of the first 3% you contribute to the Plan and 50% of the next 2% (a total of 4%). If you can't afford to save that much, make sure to save up to the matching amount so you don't leave free money behind.

Changing or Stopping Your Contributions

You may change the amount of your contributions any time. Changes are effective as soon as administratively feasible and remain in effect until you modify them. You may also discontinue your contributions and start them again at any time.

Consolidating Your Retirement Savings

If you have an existing qualified retirement plan (pre-tax) with a previous employer, you may transfer that account into the plan any time. Contact T. Rowe Price at 800-922-9945 for details.

Regardless of which retirement account you choose or how much you contribute, remember to think of it as a long-term strategy. Dipping into the account early will jeopardize the quality of your retirement and you may be subject to early withdrawal penalties from the IRS.

Investing in the Plan

It's up to you how to invest the assets. The Lhoist North America 401(k) plan offers a selection of investment options for you to choose from. You may change your investment choices any time. For more details, visit rps.troweprice.com.

CHOOSE HOW YOU WANT TO BUILD YOUR FUTURE			
	PRE-TAX	ROTH 401(K)	AFTER-TAX
Contribution category	Pre-tax	After-tax	After-tax
Eligible for employer matching contributions	Yes	Yes	Yes
Plan contribution limits	1%-50%	1%-50%	1%-10%
Current IRS limits	Combined amount of $24,500		Up to $72,000* minus employer money, employee pre-tax, and Roth 401(k) contributions
Current IRS catch-up limit (age 50+)	Combined amount of $8,000*		N/A
Higher catch-up limit (ages 60-63)	Combined amount of $11,250		N/A
Investment earnings	Tax-deferred earnings	Tax-free earnings	Tax-deferred earnings
Taxes	Contributions and earnings taxed at the time of distribution	Contributions taxed immediately, earnings tax-free for qualified withdrawals	No taxes on withdrawal of contributions; earnings are taxable as ordinary income at the time of distribution
Distributions	Contributions and earnings taxed at the time of distribution; early withdrawal penalty of 10% may apply for distributions prior to age 59.5	Tax-free if distribution is qualified (you reach age 59.5, become totally disabled, or die and it's been five years since your first Roth 401(k) contribution)	Contributions and earnings taken pro rata; earnings will be taxed; early withdrawal penalty of 10% may apply on earnings for distributions prior to age 59.5

*The IRS has not yet announced the 2027 limits.

401(k) Supplemental Contribution

In addition to the company's 401(k) match for your contributions into the plan, Lhoist also provides a quarterly 401(k) Supplemental Contribution into your account. You ARE NOT required to participate in the 401(k) Plan in order to receive the Supplemental Contribution.

- You will be 100% vested in the 401(k) Supplemental Contributions after three years of service.
- Eligibility begins on the date of hire and a participant must be employed on the last day of the calendar quarter to receive the company contribution.
- New employees' contributions will be pro-rated for the first quarter of employment based on the number of days employed during the quarter.
- The contribution percentage is based on regular earnings and years of service on the calendar quarter prior to when contributions are made. Contributions will be deposited into the participant's account in the month following each quarter.

EMPLOYER CONTRIBUTION	
YEARS OF SERVICE	PERCENTAGE
1 to 4 years	4%
5 to 9 years	6%
10 to 14 years	8%
15+ years	10%

FINANCIAL WELLNESS

Schedule Your Free Financial Wellness Consultation

Everyone deserves a financially healthy future. That's why Lhoist North America offers free access to a personal Financial Wellness Consultant from our retirement advisor, **Creative Planning**. All discussions are confidential, and no information will be shared with Lhoist.

How it Works:

Book your one-on-one appointment at a time that works best for you. Before you meet, consider gathering statements or usernames and passwords for key financial accounts (e.g., your checking/ savings account, credit cards, student loans, investments, 401(k)s, IRAs, 403(b)s, and insurance policies). It can be helpful to have a Benefits Summary of the benefits you've enrolled in, too.

How it Works:

FINANCIAL FOUNDATIONS

Budgeting
Emergency savings
Cashflow priorities

DEBT MANAGEMENT

Credit scores
Debt reduction strategies
Student loan options

BENEFITS OPTIMIZATION

Insurance coverage
Tax reduction options (Roths, HSAs, FSAs)
Retirement readiness
Social Security and Medicare

WEALTH BUILDING

Investing
Tax efficiency
Estate planning
Life insurance

To schedule a meeting with your Financial Wellness Consultant, Claudia Nybo, scan the QR code, email claudia.nybo@creativeplanning.com, or call 512-537-4997

Creative Planning, LLC, does not guarantee that the results of their advice or recommendations or the objectives of an investment option will be achieved. All investments involve risk, including the loss of principal. There can be no assurance that any financial strategy will be successful.

CREATIVEPLANNING.COM

Additional Benefits

Lhoist North America wants you to succeed in all aspects of life, so we offer a variety of additional benefits to make your day-to-day easier.

Employee Assistance Program

We're here for you when you need help. Our Employee Assistance Program (EAP) through AllOne Health helps manage your family's total health, including mental, emotional, and physical. And there's no cost to you — whether or not you're enrolled in a company-sponsored medical plan.

Through your Employee Assistance Program, you will have access to licensed professionals, resources, and information that can get you through life's challenges. All services provided are confidential.

AllOne Health is available 24 hours a day, seven days a week to help with your needs.

Phone: 855-775-4357

Online: http://allonehealth.com/reliance-matrix

Company Code: RSLI859

The Program provides referrals to help with:

- Emotional health and wellbeing
- Alcohol or drug dependency
- Marriage or family problems
- Job pressures
- Stress, anxiety, depression
- Grief and loss
- Financial or legal advice

Identity Theft Protection

LifeLock Benefit Elite helps protect your 401(k) and other investment accounts from fraudulent withdrawals and balance transfers. LifeLock also searches over a trillion data points every day for potential threats to its members' personal identity, including suspicious uses of name, address, phone number, birth date, and Social Security number to obtain loans, credit and services, or to commit crimes. LifeLock Benefit Elite helps detect potential fraud and brings it to your attention through alerts via the company's network via email, text or phone.

If you become a victim of identity theft while a LifeLock member, LifeLock will spend up to $1 million to hire the necessary lawyers, accountants and investigators to help with recovery.

Disclaimer: No one can prevent all identity theft.

LifeLock does not monitor all transactions at all businesses. Million Dollar Protection Package benefits are provided by a Master Policy issued by United Specialty Insurance Company, Inc. (State National Insurance Company, Inc. for NY State members). The Master Policy provides coverage for Stolen Funds reimbursement and Personal Expense Compensation, each with limits of up to $1 Million for Benefit Elite members, and up to $1 Million for Ultimate Plus members. If needed, LifeLock will provide lawyers and experts under the Service Guarantee. Please see the policy terms, conditions and exclusions at: LifeLock.com/legal.

BIWEEKLY CONTRIBUTIONS	
PLAN OPTIONS	
EMPLOYEE ONLY	$3.92
FAMILY	$7.84

Tuition Assistance Programs

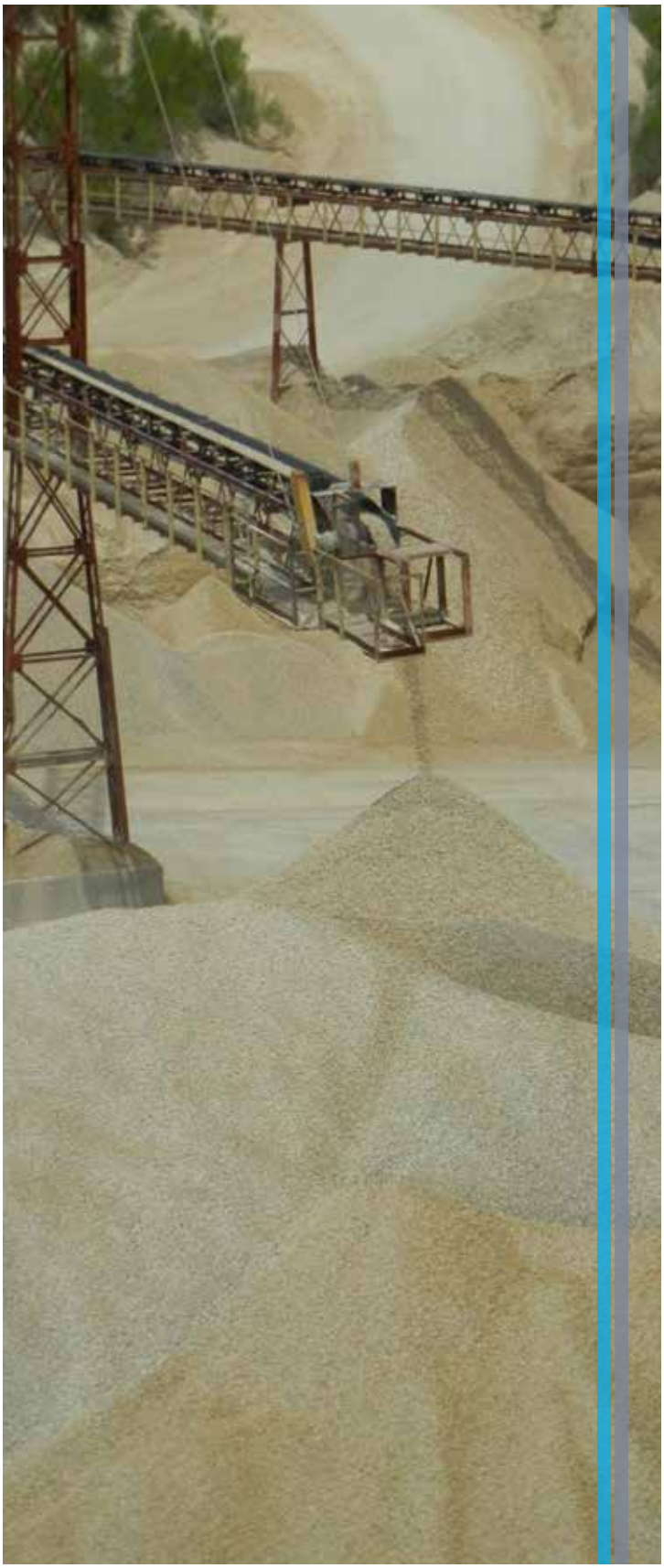
Lhoist provides two programs that can help further your education. You must be an employee for at least 6 months to be eligible to participate in the programs. You can either do the traditional tuition reimbursement program or take advantage of our partnership with Bellevue University or do BOTH! Please review the full policy for the repayment schedule if an employee voluntarily leaves the company.

Tuition Reimbursement

- Applies to secondary and graduate programs.
- Certifications are not eligible under this policy.
- The company will reimburse for tuition, books, and mandatory fees. One half of the request will be paid upon receipt of the approved application and receipts showing full payments of tuition, books, and mandatory fees. The remaining balance will be paid once the employee submits a copy of the final passing grade of C or higher.
- Maximum annual reimbursement is $5,250.

Bellevue University

- Lhoist partnered with Bellevue to provide an additional benefit in addition to the Tuition Reimbursement Policy. Note: Degree programs and some certifications are available.
- You must max out on the Tuition Reimbursement Policy first before you can be eligible for the Bellevue grants.
- Immediate Family Members are eligible also.
- Accelerated programs with 4 semesters per year instead of 2.
- Tuition is not required to be paid at the time of enrollment due to our partnership but other expenses such as books are required at the time of enrollment.
- Maximum annual grant:
  - Full-time employees: $5,250
  - Part-time employees: $5,250
  - Immediate Family Members: $3,500



Required Notices

Important Notice From Lhoist North America About Your Prescription Drug Coverage and Medicare Under the BCBSTX PPO and HDHP Plan(s)

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

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

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

2. Lhoist North America has determined that the prescription drug coverage offered by the BCBSTX PPO and HDHP plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Lhoist North America coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

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

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed at the end of these notices for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Lhoist North America changes. You also may request a copy of this notice at any time.

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 drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227).
  TTY users should call 1-877-486-2048

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

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

Date:	January 1, 2027
Name of Entity/Sender:	Lhoist North America
Contact—Position/Office:	LNA Benefits Team
Address:	5600 Clearfork Main Street, Suite 300 Fort Worth, TX 76109
Phone Number:	800-286-0134

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact LNA Benefits Team at 800-286-0134.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact LNA Benefits Team at 800-286-0134.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and 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 dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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

To request special enrollment or obtain more information, contact LNA Benefits Team at 800-286-0134.

Illinois Essential Health Benefit (EHB) Listing

Employer Name: Lhoist North America

Employer State of Situs: Texas

Name of Issuer: BCBS of Texas

Plan Marketing Name: PPO and HDHP

Plan Year: 2027

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
1	Accidental Injury – Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing		Pg. 11	Yes
3	Bone Anchored Hearing Aids		Pgs. 17 & 35	Yes
4	Durable Medical Equipment		Pg. 13	Yes
5	Hospice		Pg. 28	Yes
6	Infertility (Fertility) Treatment		Pgs. 23 - 24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)		Pgs. 15 - 16	Yes
9	Private-Duty Nursing		Pgs. 17 & 34	Yes
10	Prosthetics/Orthotics		Pg. 13	Yes
11	Sterilization (Vasectomy Men)		Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)		Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency Services	Pg. 7	Yes
14	Emergency Transportation/Ambulance		Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy		Pgs. 24 – 25	Yes
17	Reconstructive Surgery		Pgs. 25 – 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)		Pg. 15	Yes
19	Skilled Nursing Facility		Pg. 21	Yes
20	Transplants – Human Organ Transplants (Including Transportation & Lodging)		Pgs. 18 & 31	Yes

2020-2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
21	Diagnostic Services	Laboratory Services	Pgs. 6 & 12	Yes
22	Intranasal Opioid Reversal Agent Associated with Opioid Prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)		Pgs. 8 – 9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)		Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)		Pgs. 9 & 21	Yes
26	Tele-Psychiatry		Pg. 11	Yes
27	Topical Anti-Inflammatory Acute and Chronic Pain Medication		Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See All Kids Pediatric Dental Document	Yes
29	Pediatric Vision Coverage		Pgs. 26 – 27	Yes
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription Drugs	Pgs. 29 – 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services		Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education		Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes		Pgs. 31– 32	Yes
36	Mammography – Screening		Pgs. 12, 15, & 24	Yes
37	Osteoporosis – Bone Mass Measurement		Pgs. 12 & 16	Yes
38	Pap Tests/Prostate-Specific Antigen Tests/Ovarian Cancer Surveillance Test		Pg. 16	Yes
39	Preventive Care Services		Pg. 18	Yes
40	Sterilization (Women)		Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 – 13	Yes
42	Habilitative and Rehabilitative Services		Pgs. 8, 9, 11, 12, 22, & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

Notes

Lhoist North America