

EMPLOYEE BENEFITS ENROLLMENT GUIDE



Effective April 1, 2026

WELCOME

At **Superior Ready Mix**, we are proud of our accomplishments, and we recognize the importance of delivering a comprehensive benefits program. Our program was developed to provide you and your eligible dependents with multiple benefit choices to support your needs.

Some of the overriding objectives in developing the benefits program include:

- Meeting the diverse needs of our Employees by offering flexible benefit choices
- Providing financial protection for you and your loves ones
- Establishing a partnership with you – and all Employees – to control costs
- Providing programs that promote overall wellbeing with easy access to health resources

This booklet was developed to assist you in understanding your choices for coverage and resources available to you and your family. An overview of each benefit, along with plan highlights, are included for your review. For detailed information including limitations and exclusions, refer to the summary plan descriptions (SPDs) and summary of benefits coverage (SBCs).

Please reach out to Human Resources at benefits@superiorm.com with any questions you may have regarding the benefits available to you.

Important Legal Information

This guide has been written as clearly and accurately as possible but contains only brief summaries of the employee benefit plans. Each plan is governed by legal documents, such as policies, contracts and/or summary plan description (SPD) booklets. If there is a difference of opinion or question about benefit determination, the legal documents will govern.

This guide does not serve as a guarantee of continued employment or benefits. We, as the plan sponsor, reserve the right to change, amend or terminate any of the plans or benefits for any class of participants, and/or modify the classes of participants eligible for benefits, at any time.

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ELIGIBILITY

Superior Ready Mix provides eligible employees with a comprehensive employee benefit package.

The employer sponsored plans for employee and family coverage are as follows:

- Medical
- Dental
- Vision
- Life and AD&D Insurance
- Profit Sharing Plan

Employees may also elect participation in:

- Voluntary Life and AD&D Insurance
- Health Care FSA and Dependent Care FSA
- 401(k) Retirement Plan (new hires auto enrolled)



Eligible Employees

Regular full-time employees working at least 30 hours per week are eligible for benefits. Employees become eligible to participate in the various insurance plans (except for profit sharing and 401(k)) on **the first of the month following one consecutive month of employment.**

If you enroll, you have the option of covering your eligible dependents.

Eligible Dependents

- Your legal spouse
- Your children up to age 26
 - Natural, adopted, stepchildren or children
 - Children for whom the employee or spouse has been assigned legal guardianship
 - Children named in a Qualified Medical Support notice
- Your children of any age who are physically or mentally disabled. You will be required to provide verification that the child meets these conditions.

Who Is Not Eligible?

Members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings
- Employee who work less than 30 hours per week, temporary employees not on Superior Ready Mix's payroll, contract employees, or employees residing outside the United States.

ENROLLMENT

When to Enroll

The choices you make when you first become eligible will remain in effect for the remainder of the plan year. It is important to review your benefit options and choose the best coverage for you and your family during this time.

These are the opportunities to enroll or make changes to your benefit elections:

- **Newly Hired Employees** must make benefit elections within two weeks of your date of hire. If you do not enroll for coverage during your initial eligibility period, you must wait until the next open enrollment period unless you have a Qualifying Life Event.
- Each year during the **Open Enrollment** which occurs prior to the beginning of the upcoming plan year (April 1), eligible employees are offered the opportunity to change their benefit elections. The coverage you elect during Open Enrollment cannot be changed during the plan year unless you have a Qualifying Life Event.
- Within 31 days of a **Qualifying Life Event (QLE)** as recognized by IRS guidelines (the chart to the right). Employees are responsible for notifying Human Resources of all changes to their benefit status, including coverage dependents.

Things to Consider

If it is important to you to keep your current doctor or dentist, please confirm that they will continue to participate in your selected health plan's network as there may occasionally be changes. For the most up-to-date information regarding participating providers, visit the plan's web site or call your physician.

Qualifying Events

You cannot change your plan selections, add or drop dependent coverage until the next open enrollment period unless you have a qualified change in status as defined by the IRS Section 125 rules. Examples include:

- Marriage, domestic partnership, death of spouse, divorce, legal separation, or annulment;
- Birth of a baby, adoption, placement for adoption or death of a dependent;
- Termination or commencement of employment by the employee, spouse or dependent;
- Reduction or increase in hours of employment by the employee, spouse or dependent, including a switch between part-time and full-time, or commencement or return from an unpaid leave of absence;
- Dependent no longer meets the eligibility requirements under the health plan. (i.e dependent child turns age 26);
- Change in your residence or worksite, which causes a loss or gain in coverage for the employee, spouse or dependent;
- Becoming eligible for or losing coverage under a state's premium assistance program through Medicaid/CHIP

Alliant Benefits Advocate

Need help with your benefits?

Email your Benefits Advocate today!

Alliant Insurance Services provides **Superior Ready Mix's** valued employees with your personal Benefits Advocate.

The Alliant Benefits Advocate can help with:

- Locating a provider
- Insurance claim questions
- Prescription problems
- Benefit questions or access problems that you are unable to resolve through your provider or health care plan

For assistance, email us at: mybenefitsteam@alliant.com



HOW TO ENROLL

Greenshades

Greenshades is the enrollment platform that will be used for benefit elections. Elections can be made on a mobile device where you will also be able to view current elections for yourself and dependents, confirm selections and premiums for the new year.

Enrolling is easy through Greenshades. Take care of your benefits by following a few simple steps.

If you have any questions contact benefits@superiorm.com for assistance.

Before you Enroll:

- Sign in to your Greenshades account at srm1.greenemployee.com (DO NOT USE THE APP).
- If this is your first time using Greenshades, click Register at the bottom of the screen.
- Once signed in, under the Menu, click the Benefits tab to access your enrollment.

Note: To add a NEW dependent, you must click the HR Profile tab, then Dependents. Enter your dependent's information and email Proof of Relationship to benefits@superiorm.com for HR approval.



❑ Sign In or Register



Sign in

Email, Phone Number, or Employee ID

Sign in

[Need help signing in?](#)

New User? [Register](#)

HOW TO ENROLL

Verify your Identity


Verify your identity


We'll send you a one-time use code to verify your identity.


If you do not recognize the contact information below,


do not continue with verification.

Please contact your administrator.

 Text code to
(8**)-***-**55

 Call code to
(8**)-***-**55

 Email code to
a*****er@superiorm.com

 Sign in with password



Enter verification code

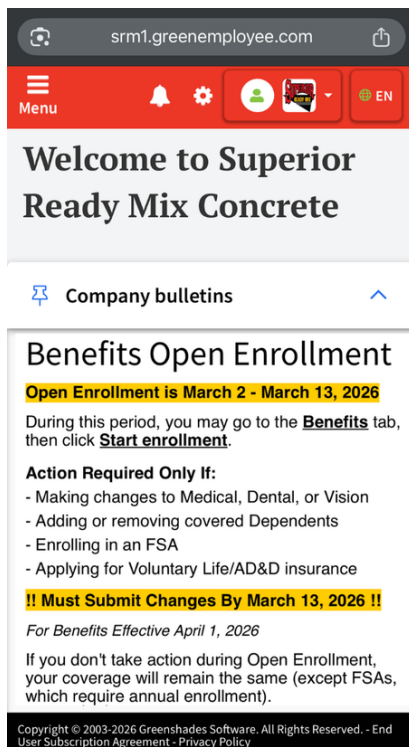
To access your account, please enter the verification code sent by text message to (8**)-***-**55

Code






Next

[Resend code](#)



Once signed in, under the Menu, click the Benefits tab to access your enrollment



srm1.greenemployee.com

Menu     

Welcome to Superior Ready Mix Concrete

 Company bulletins 

Benefits Open Enrollment

Open Enrollment is March 2 - March 13, 2026

During this period, you may go to the **Benefits** tab, then click **Start enrollment**.

Action Required Only If:

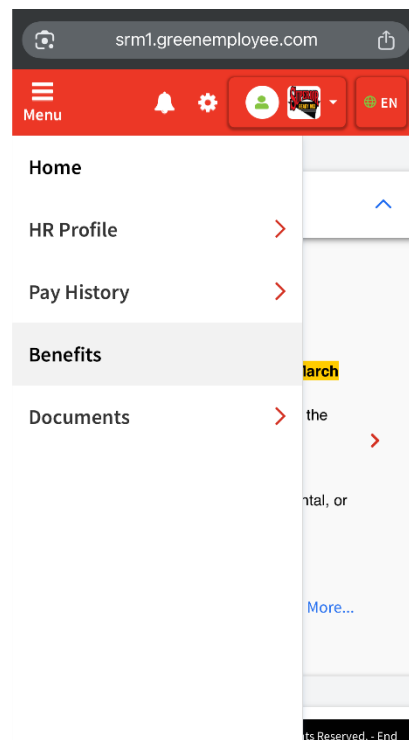
- Making changes to Medical, Dental, or Vision
- Adding or removing covered Dependents
- Enrolling in an FSA
- Applying for Voluntary Life/AD&D insurance

!! Must Submit Changes By March 13, 2026 !!






For Benefits Effective April 1, 2026






If you don't take action during Open Enrollment, your coverage will remain the same (except FSAs, which require annual enrollment).

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srm1.greenemployee.com

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- Pay History 
- Benefits** 
- Documents 

ts Reserved. - End

MEDICAL BENEFITS

Know Your Options

We offer two comprehensive medical plans with one accessing care in the United States and one accessing care across the border.

Anthem Blue Cross PPO (Preferred Provider Organization) offers members access to medical care through physicians and hospitals contracted with Anthem Blue Cross in the United States. Members have the freedom to choose any provider or hospital without the necessity of a designated primary care physician.

Members utilizing Anthem providers will receive many cost advantages such as copayments for most services and no deductibles. If you do choose to see an Out-of-Network provider, you will pay a percentage of the cost of the services provided.

Choosing your doctor

You are not required to select a Primary Care Physician (PCP). You are encouraged to seek the care of a PCP for your annual exams and other preventive care services.

Accessing care

- **In-Network** – Choose to see doctors or other health professionals who participate in the Anthem PPO network to keep your costs lower and eliminate paperwork.
- **No-referral specialist care** – If you need to see a specialist, you do not need a referral to see a doctor who participates in the Anthem PPO network – make the appointment and go! Pre-certification may be necessary for hospitalizations and other types of outpatient care.
- **Out-of-Network** – You have the freedom to visit providers that are not part of the Anthem PPO network, but your costs will be higher and you may need to file a claim.
- **Emergency care** – When you need care, you're covered, 24 hours a day worldwide.



Network Access Level	Anthem PPO Medical	
	In-Network	Out-of-Network
Lifetime Benefits	Unlimited	
Annual Out-of-Pocket Maximum	\$1,000 (3x family)	\$1,500 (3x family)
Annual Deductible	None	\$250 (3x family)
Preventive Care		
Primary Care Office Visits	\$25 copay	30% after deductible
Specialists Office Visits	\$40 copay	30% after deductible
Routine GYN and Well Child Visits	No Charge	30% after deductible
Preventive Care (i.e. immunizations, age appropriate screenings)	No Charge	30% after deductible
Inpatient/Outpatient Care		
Urgent Care Visits	\$50 copay	30% after deductible
Emergency Room Services	\$250 copay	30% after deductible
Diagnostic Lab & X-Ray	No Charge	30% after deductible
Inpatient Hospitalization	\$500 copay	30% after deductible
Outpatient Surgery	\$150 copay	30% after deductible
Other Services		
Physical Therapy	\$25 copay	30% after deductible
Outpatient Mental Health	\$25 copay	30% after deductible
Chiropractic and Acupuncture	\$25/visit; 20 visits/year	30% after deductible
Teladoc	No Charge	No Charge
Prescriptions		
Generic Prescriptions	\$10 copay	Not covered
Brand Name Prescriptions	\$25 copay	Not covered
Non-Preferred Prescriptions	\$50 copay	Not covered
Mail Order	2x copay = 90 days	n/a

For more information on how to find an Anthem Provider visit hconline.healthcomp.com or download the app.

MEDICAL BENEFITS

SIMNSA HMO (Health Maintenance Organization) is a Cross Border (Baja) Plan that offers members the ability to obtain services from providers in Mexico. With this plan, there is no annual deductible and services are covered in full after a copayment with hospital services being covered at 100%. You must choose a primary care physician (PCP) from the SIMNSA network of physicians. Your PCP will coordinate your medical care, including referrals to specialists. Only Urgent Care and Emergency Care can be accessed outside of Mexico.



	SIMNSA Cross-Border HMO Medical
Network Access Level	In-Network
	Member Pays...
Lifetime Benefits	Unlimited
Annual Out-of-Pocket Maximum	\$6,350 Individual/\$12,700 Family
Annual Deductible	None
Preventive Care	
Primary Care Office Visits	\$7 copay
Specialists Office Visits	\$7 copay
Routine GYN and Well Child Visits	No Charge
Preventive Care (i.e. immunizations, age appropriate screenings)	No Charge
Inpatient/Outpatient Care	
Urgent Care Visits	\$25 copay (\$50 copay if out of service area)
Emergency Room Services	\$250 copay
Diagnostic Lab & X-Ray	No Charge
Inpatient Hospitalization	No Charge
Outpatient Surgery	No Charge
Other Services	
Physical Therapy	\$10 copay
Outpatient Mental Health	\$7 copay
Chiropractic Services	Not Covered
Prescriptions	
Generic Prescriptions	\$10 copay
Brand Name Prescriptions	\$10 copay
Non-Preferred Prescriptions	\$10 copay
Mail Order	n/a

SIMNSA Website simnsa.com

Visit the website for more information including:

- Schedule and cancel appointments
- Review your visit history and test results
- Search locations and providers
- View Benefits Summary
- Registering is easy! All you need is your SIMNSA ID and Date of Birth

SIMNSA Advantages

- Clinics are open 7 days a week
- Grupo Medyca in Tijuana is open until midnight
- No appointments necessary, walk-ins are welcome
- Clinic wait time is reduced by use of an electronic monitoring system
- Patients can cross back FASTER using the medical pass lane

Additional Benefits

- Online medical records
- SENTRI pass reimbursement program
- Transportation available in Mexicali
- Massage therapy and Acupuncture
- Spa services are discounted for members
- “One stop” medical clinic where all services can be rendered
- Members have access to online appointment scheduling system

PRESCRIPTION COVERAGE

Anthem Members

RxBenefits is your pharmacy benefit administrator. They have partnered with Express Scripts to bring **Superior Ready Mix** members greater discounts, better access, and improved member services.

Important Information

If you need to fill a script prior to receiving your ID card, below is the information your pharmacy needs in addition to your identification number or social security number:

RXBIN: 003858
RXPCN: A4
RxGRP: RXBSRMC
Issuer: Express Scripts
Pharmacy Member Services: 800-334-8134
Pharmacist Helpdesk: 800-922-1557

ESI Formulary

In the event you want to see if the medication you are being prescribed is covered, you can always look at the formulary at the following link: express-scripts.com

Mandatory Mail

Express Scripts Mail Order Program (90-Day supply): The Prescription Drug Card Program requires using the mail order benefit for maintenance medications. Maintenance medications are those that treat an ongoing condition such as high blood pressure, diabetes or cholesterol. You can get up to two (30-day supply) fills from your local participating pharmacy with no penalty. If you continue to use retail for your maintenance medication you will have a higher copay for each refill.

Express-Scripts Mobile App

Manage your medication. Anytime, Anywhere.

With the Express Scripts mobile app, you can manage your medications, view orders, access your ID card, order refills, make payments, check drug interactions or find the closest retail pharmacy. Download the Express Scripts mobile app for FREE!

	
EXPRESS SCRIPTS	
Member Pays...	
Prescriptions	<i>Retail 30-Day Supply</i>
Generic Birth Control	No charge
Generic Drugs	\$10 copay
Formulary Brand Name	\$25 copay
Non-Formulary Brand Name	\$50 copay
	<i>Home Delivery 90-Day Supply</i>
Generic Drugs	\$20 copay
Formulary Brand Name	\$50 copay
Non-Formulary Brand Name	\$100 copay

Express-Scripts.com

On or after your effective date, you can register online at Express-Scripts.com. As a registered member, you'll have a powerful tool to help you lower your prescription costs and save time. You can take a quick tour of the website to understand how to use it before you register. Once you register, you can get started with Mail Order, check prices and coverage and view your Rx claims.

If you have an Express-Scripts account already set-up, there is no need to re-register.

Register with Express Scripts. Visit the website or download the app at express-scripts.com

My RxBenefits

Online Access to Your Pharmacy Benefits

By registering for My RxBenefits, you'll gain access to robust information related to your pharmacy benefits.

Access your information when it's convenient for you, anytime, 24 hours a day, 7 days a week.

My RxBenefits will allow you to

- Access real-time prior authorization status
- View updates for alternative medication therapies related to anti-inflammatory and dermatological conditions
- View 18 months of pharmacy claims
- View, download and email copies of ID cards
- Access account across multiple devices

Sign up to be notified when the portal is available:

[Signup RxBenefits](#)

VIRTUAL CARE

When you need care NOW

Teladoc Health gives you 24/7/365 access to a doctor through the convenience of phone, video or mobile app visits. It's a FREE alternative to costly urgent care and ER visits when you need care now.

Teladoc Health is simply a new way to access qualified doctors. Teladoc Health doctors:

- Are practicing primary care physicians, pediatricians, and family medicine physicians
- Average 20 years' experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

When should you use Teladoc Health?

Teladoc Health does not replace your primary physician. Consider Teladoc Health:

- When you need care now
- If you're considering the ER or urgent care for a non-emergency
- If your primary care physician is not available
- When on vacation, a business trip or away from home
- For short-term prescription refills

Teladoc Health is just a call or click away!

To get started:

- Download the app
- [Teladoc.com](https://www.teladoc.com)
- apps.apple.com
- (800) Teladoc (835-2362)

Registration

It's quick and easy to set up your account online. Simply visit the Teladoc Health website, click "Sign in" or "Register now," and then follow the instructions below.

1. Confirm Benefits

Provide some information about yourself to confirm your eligibility.

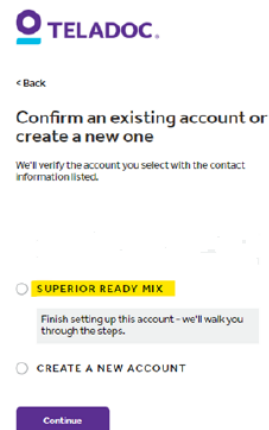
Do not check the "I received a Teladoc code from my employer or insurance company".

2. Find your coverage

Confirm the coverage that has been matched to you and click "Next" to proceed with account set up.

For members who have multiple coverage through another benefit provider or have an existing account":

- If registering via the app, select Superior Ready Mix as your benefits.
- Members who call should indicate their benefits originate from Superior Ready Mix.



3. Create an Account

Enter your contact information, username, password and security questions.

Teladoc Health doctors can treat many medical conditions, including:

- Allergies
- Cold & flu symptoms
- Fever
- Mental Health
- Pain
- Rashes
- Sinus problems
- Respiratory infection
- Skin problems
- And more!

PREVENTIVE CARE

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

When you get routine preventive care from an in-network provider, you don't pay for it—your health plan does. Under the Affordable Care Act, health plans cover certain preventive services at no out-of-pocket cost to you, such as:

- Routine wellness exams
- Screenings and tests
- Vaccinations
- Medications and supplements
- Reproductive and women's health

Not all exams and tests are preventive

Exams performed by specialists are not generally considered preventive. Certain screenings may be considered diagnostic based on any current medical conditions. You may be responsible for paying all or a share of the cost for those services. If you have a question about whether a service will be covered as preventive care, contact your medical plan.

Preventive Care Screenings for Adults

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer
- Depression
- STIs



Preventive care for women should also include breast and gynecological exams



For men, preventive care should also include prostate cancer screening and a testicular exam



For children, well-baby and well-child preventive care should include height, weight, head circumference, BMI and blood pressure



U.S. Department of Health and Human Services






Visit health.gov/myhealthfinder for recommended guidelines



KNOW WHERE TO GO

Medical Benefits

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

	Type	Examples
	HEALTH PLAN NURSE LINE (24/7—\$0) Quick answers from a medical professional	Identifying if immediate care is needed Home treatment options and advice
	VIRTUAL ONLINE VISIT (24/7—\$0 -\$\$) Many non-emergency health issues	Cold, flu, allergies, headache, migraine Skin conditions, rashes Minor injuries Mental health concerns
	OFFICE VISIT (\$\$) Routine medical care and management	Preventive care Illnesses, injuries Managing existing conditions
	URGENT CARE (\$\$\$) Non-life-threatening conditions requiring prompt attention	Stitches, sprains Animal bites High fever Respiratory infection
	EMERGENCY ROOM (24/7—\$\$\$\$) Life-threatening conditions needing immediate care	Suspected heart attack or stroke Major bone breaks Excessive bleeding Severe pain Difficulty breathing

TIP: Find the nearest In-Network urgent care facilities in your area before you need them so you are prepared should you ever need one.

DENTAL BENEFITS

Know Your Options

We offer all eligible employees two Dental plans that are outlined below. Both dental plans offer routine preventive care coverage at no cost.

Our Plans

Western Dental DHMO (Dental Health Maintenance Organization) services are coordinated through a designated primary care dental group chosen from the list of contracted dental offices. They will perform the covered procedures or refer you to a specialty care dentist for further care. Treatment by an Out-of-Network dentist is not covered, except as described in the Summary Plan Description. This program is designed to encourage regular dental visits to maintain dental health. Many services are covered at no cost, while others have set copayments. There is no deductible or annual limit on dental benefits under the Western Dental DHMO.

Superior Indemnity Plan is an Indemnity plan that allows members the freedom to see any dentist they choose. After the deductible is satisfied, the plan will pay a percentage of the reasonable and customary costs for the services provided. The member will pay the balance. The plan will pay up to a maximum of \$2,000 per covered person per year.



	WESTERN DENTAL DHMO	SUPERIOR READY MIX Indemnity
Network Access Level	DHMO	Indemnity
Annual Benefit Maximum	Unlimited	\$2,000
	Members pays.....	Members pays.....
Deductible (Individual/Family)	None	\$50/\$150
Deductible Waived for Preventive	None	Yes
Preventive Care		
Cleaning/X-rays	No charge	No charge
Basic Services		
Root Canal/Extractions	Refer to Schedule of Benefits	15%
Major Services		
Implants	Refer to Schedule of Benefits	45%
Crowns/Dentures	Refer to Schedule of Benefits	45%
Orthodontia		
Adult	\$2,100	Not covered
Child	\$1,600	Not covered



- Don't forget about your semi-annual Dental Cleanings!
- If services are estimated to be \$350 or more have your dentist submit a pre-determination of benefits to ensure that services are covered and to receive an estimate of what the plan will pay


For more information, call:


DHMO: Western Dental [800-992-3366](tel:800-992-3366)

Indemnity: Personify Health Member Services [800-442-7247](tel:800-442-7247)

VISION BENEFITS

Superior Ready Mix offers a comprehensive vision plan through **EyeMed**, a network that gives you lots of choices and flexibility. You can choose from thousands of independent and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, your plan is designed to be easy to use and help you access the care you need. With EyeMed you can utilize one provider for both your examination and eyewear materials or you can receive your examination from one provider and your materials from another provider. The *Choice* is yours!

Savings plus more with Eye360 is a way for members to save. When visiting **PLUS Providers**, members receive an additional \$50 frame allowance and \$0 exam copay. **PLUS Providers** are easy to find including independent, retail and online options. Just look for the **PLUS Provider** icon  online.

	EyeMed Vision Care	
	In-Network	Out-of-Network
	Member pays...	
Examination		
Benefit	\$15 copay	up to \$40 allowance
Exam at PLUS Providers	\$ 0 copay	up to \$40 allowance
Frequency	Once every 12 months	Once every 12 months
Eyeglass Lenses		
Single Vision Lens	\$10 copay	up to \$30 allowance
Bifocal Lens	\$10 copay	up to \$50 allowance
Trifocal Lens	\$10 copay	up to \$70 allowance
Frequency	Once every 12 months	Once every 12 months
Frames		
Any available frame at PLUS Providers	up to \$170 allowance	up to \$84 allowance
Retail	up to \$120 allowance	up to \$84 allowance
Wholesale*	\$84 allowance	up to \$84 allowance
Frequency	Once every 24 months	Once every 24 months
Contacts (In-lieu of glasses)		
Conventional	up to \$120 allowance	up to \$84 allowance
Disposable	up to \$120 allowance	up to \$84 allowance
Medically Necessary	No charge - 100%	up to \$300 allowance
Frequency	Once every 12 months	Once every 12 months

* Available at wholesale providers, such as Costco Optical; discounts do not apply.

Other Services Covered

Further discounts are available with this plan including:

- 40% off additional pairs of glasses
- 15% discount on conventional lenses once funded benefit is used
- 20% off non-prescription sunglasses
- Save money on Lasik procedures and hearing aids

For more information, visit: eyemed.com



LIFE AND AD&D

Company-Paid Life and AD&D

Superior Ready Mix invests in your family's financial peace of mind by providing Basic Group Term Life and Accidental Death and Dismemberment (AD&D) in the amount of \$50,000 through Reliance Standard at no cost to you.

Why Life Insurance Matters

Life Insurance is a cost-effective way to protect your loved ones. Should something unforeseen happen to you, it helps ensure that short-and long-term financial obligations could be met. If you have a spouse or domestic partner, if you have children, they may rely on you to help keep the household running. Without your income, paying the mortgage or providing for a child's college education could become more difficult. AD&D provides even more coverage if you pass away or suffer a covered loss in an accident.

Life Insurance gives your loved ones a lump sum payment. This would help them be financially prepared to better handle expenses like:

- Mortgage or rent payments
- Utilities
- Insurance premiums
- Childcare/education fees
- Transportation
- Credit card bills

Designate a Beneficiary!

It is important to review your beneficiary designations periodically to ensure current information is on file. You can update your beneficiary at anytime during the year.

Voluntary Life and AD&D

If you determine you need more than the company paid Basic Group Term Life/AD&D, you may purchase supplemental coverage for yourself and your eligible dependents. Employees pay 100% of the premium through a convenient deduction from your paycheck.

Employee:

- You can enroll for up to 5 times your annual salary up to a maximum amount of \$500,000
- New hire guaranteed issue amount of \$100,000

Spouse:

- You may also purchase spouse coverage up to 50% of your benefit, not to exceed \$250,000
- New hire guaranteed issue amount of \$50,000

Child(ren):

- Coverage for your children is also available in the amount of \$2,000 to \$10,000
- Guaranteed issue

Employee and Spouse rates are based on current age and increase as you enter each new age group.



EMPLOYEE ASSISTANCE PROGRAM (EAP)

Our Employee Assistance Program (EAP) through AllOne Health and Reliance Matrix is designed to help you and your loved ones with a wide variety of life's challenges including personal, work and family, caregiving, bereavement, legal, financial, and pet care issues.

EAP benefits are free of charge, **100% confidential** and professional services are available to all family members regardless of location and easily accessible through All One Health 24 hours a days, 7 days a week, live-answer, toll-free number.

From the stress of everyday life to relationship issues or even work-related concerns, the EAP can help with any issue affecting overall health, well-being and life management.

- Up to 3 Sessions of Professional Assessment for Employees and Family Members
- Unlimited Telephonic Clinical Assessment and Referral
- Unlimited Child Care and Elder Care Referrals
- Legal Consultation for Unlimited Number of Issues per Year
- Financial Consultation for Unlimited Number of Issues per Year
- Unlimited Pet Care Consultation
- Unlimited Education Referrals and Resources
- Unlimited Referrals and Resources for any Personal Service
- Unlimited Community-based Resource Referrals
- Online Legal Resource Center
- Multicultural and Multilingual Providers Available Nationwide

Contact AllOne Health

855-775-4357

reliance-matrix.mylifeexpert.com



WORK/LIFE BALANCE



It is the policy of **Superior Ready Mix** to provide a competitive program of paid holiday and time off from work to allow employees the necessary time for mental, physical and emotional relaxation. Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle.

Paid Vacation (Full-Time Employees)			
Length of Service (Years)	Annual Accrual (Weeks)	Annual Accrual (Hours)	Weekly Accrual Rate (Hours/Week)
Less than 1	1 week	40	0.77
1 - 4	2 weeks	80	1.54
5 - 14	3 weeks	120	2.31
15+	4 weeks	160	3.08

New Hires begin accruing Paid Vacation time immediately, however, there is a 6-month waiting period for New hires to use Paid Vacation time.

CA Paid Sick Leave
In addition to Vacation, employees are provided 40 hours Paid Sick Leave per year.

There is a 90-day waiting period for New Hires to use Paid Sick Leave. Paid Sick Leave is then reloaded each January 1.

Paid Holidays (Full-Time Employees)
New Year's Day
Memorial Day
4th of July
Labor Day
Thanksgiving Day
Day after Thanksgiving
Christmas Eve
Christmas Day
*Day of Service (Martin Luther King Jr Day)
*Two Additional "Floating Holidays" can be used throughout the year

There is a 90-day waiting period for New Hires to use their Floating Holidays. These are reloaded each January 1.

Other Holidays do not have a waiting period, however, Holiday Pay will not be granted if there is an unexcused absence the workday before or the workday after the Holiday.

FLEXIBLE SPENDING ACCOUNT (FSA)

WHAT IS AN FSA?

It's an employee benefit that allows you to set aside money pre-tax to pay for eligible health care and childcare expenses for you, your spouse and dependents, even if you're not covered by your employer's insurance plan. An FSA provides significant advantages, including:

- ▶ **Immediate tax savings:** Contributions to your FSA are made on a pre-tax basis, which lowers your taxable income and may decrease the amount you pay in federal, state, local and FICA taxes.
- ▶ **Increased spendable income:** Your net income may increase each month because your contributions to the FSA lower your taxable income.
- ▶ **Better cash flow:** An FSA allows you to budget for your medical, dental, and vision expenses on a pre-tax basis. Your total Health Care FSA election is available at the beginning of the plan year, which gives you the ability to use the funds as needed yet have a small amount (election/number of pay periods) deducted from your payroll each pay date.
- ▶ **Coverage for entire family:** When making your election, remember to include expenses for yourself, your spouse, and/or your tax dependents.

HOW DOES AN FSA WORK?

There are two accounts you can contribute to – the Health Care FSA (HCFSA) and the Dependent Care FSA (DCFSA). Each year you decide how much to set aside in your accounts for the following year. That amount will be evenly deducted pre-tax payroll deductions made throughout the year. You cannot change your annual election amount mid-year unless you have an IRS qualifying event. During open enrollment, evaluate your health and dependent care situation to determine your annual election. These plans are administered by **Personify Health**

HEALTH CARE FSA (HCFSA)

The IRS has projected to increase the FSA limits. In 2026 you can set aside up to **\$3,400** in the HCFSA for many expenses including doctor's office copays, your portion of the medical deductible, dental care, glasses and contacts and even things like band-aids, first aid kits and some services that your medical, dental and vision plans may not cover. Check out the [HCFSA eligibility list!](#)

Once you are enrolled and the plan year has begun, **you have access to your funds immediately.**



DEPENDENT CARE FSA (DCFSA)

If you pay a licensed professional to care for your dependent, you can contribute up to **\$7,500** per year to the DCFSA (\$3,750 if your spouse also participates in a DCFSA). Your dependent must live with you and be 12 years old or younger or age 13 or older if they cannot physically or mentally care for themselves and require care while you're working. Unlike the HCFSA, **the available balance will only be the amount contributed.**

Eligible expenses include before and after school care, day care and day camps, preschool and elder care. Check out the [DCFSA eligibility list!](#)

Highly Compensated Employees (HCE) are ineligible to participate in the DCFSA due to Non-Discrimination Compliance. Please see HR for more information.

PROFIT SHARING/401(K)

PROFIT SHARING

Superior Ready Mix offers a Profit Sharing Plan. This plan is in place to provide assistance to you in the planning of your retirement as well as to provide incentive for productivity. Superior Ready Mix makes discretionary Profit Sharing Contributions annually. To be eligible for these contributions, employees must have at least six months of continuous employment with Superior prior to the January plan year start.

PROFIT SHARING PLAN YEAR	ELIGIBLE IF HIRED ON OR BEFORE
January 1 – December 31, 2024	June 30, 2023
January 1 – December 31, 2025	June 30, 2024
January 1 – December 31, 2026	June 30, 2025

401(k)

Superior Ready Mix sponsors a 401(k) Retirement Plan for employees. With this plan, you choose the amount of your income you would like to invest through automatic payroll deductions.

The 401(k) plan offers you an excellent opportunity to save funds for retirement because the monies are tax deferred.

With both the Profit Sharing Plan and 401(k), you have complete control over which funds to invest your money.

Because these are tax deferred plans, once the funds have been contributed, they cannot be withdrawn except in the case of certain hardships or by taking out a loan. If you terminate employment, you may roll your funds into another employer's 401(k) or an Individual IRA.



Eligibility

You are eligible to participate in the plan if you are 20 ½ years of age. New Hires are auto-enrolled in the 401(k) plan at 5% automatic payroll deductions.

It's always the right time

Saving for retirement is important for your financial future, whether you are retiring soon or years from now. The important thing is to start now and set aside what you can, even if you think it's too small an amount. The **Superior Ready Mix** 401(k) Plan is designed to assist you in meeting your retirement goals.

For more information

Please visit our employee portal at www.superiorrm.com or Fidelity's website www.401k.com to manage your account, investments and contributions. You may also:

- Update beneficiaries
- Check your account or loan balance
- Request a loan

Fidelity offers a variety of quality investment options. You'll also have access to special services such as automatic account rebalancing and personal investment assistance from a licensed investment counselor.



REQUIRED NOTICES

ERISA and various other state and federal laws require that employers provide disclosure and annual notices to their plan participants. We provide all federally required annual notices; below are summary descriptions of each notice and disclosure.

Children’s Health Insurance Program (CHIP) Notice provides information on how to contact your state Medicaid office to receive information on assistance if you are eligible for health coverage from your employer but are unable to afford the premiums.

Health Insurance Marketplace Notice provides basic information about the Marketplace and coverage offered by your employer.

General Notice of COBRA Rights explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.

The “No Surprises” Rules Protect you from surprise medical bills in situations where you can’t easily choose a provider who’s in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers.

Family and Medical Leave Act (FMLA) enables eligible employees who work for a covered employer to take up to 12 weeks of unpaid, job-protected leave in a 12-month period for specific family reasons. An eligible employee who is a covered service member’s spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness.

General Notice of Uniformed Services Employment and Reemployment Rights Act (USERRA) protects job rights of individuals who leave employment positions to undertake military service or certain types of service in the National Disaster Medical System and prohibits employers from discriminating against members of the uniformed services, and applicants to the uniformed services.

Medicare Part D Creditable Coverage Notice states that Medicare prescription drug coverage offered by your employer is on average expected to pay out as much as standard Medicare coverage pays and is therefore considered Creditable Coverage.

Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA) protects the amount of time a mother and her newborn child are covered for a hospital stay following childbirth.

Notice of Patient Protections states that you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, the medical carrier designates one for you.

Notice of Special Enrollment Rights provides information on special enrollment periods (outside of Open Enrollment) for loss of prior coverage or addition of a new dependent.

Notice of Privacy Practices describes how health information about you may be used and disclosed.

Women’s Health and Cancer Rights Act (WHCRA) of 1998 protects breast cancer patients who choose breast reconstruction with a mastectomy. The US Departments of Labor and Health and Human Services are in charge of this act of law, which applies to group health plans if the plans or coverage provide medical and surgical benefits for a mastectomy.

GLOSSARY OF HEALTH COVERAGE TERMS

These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs.

EMPLOYEE CONTRIBUTION The portion an employee contributes towards their benefits through payroll deductions.

COPAY The amount which a covered individual is required to pay for certain services after meeting any applicable deductible.

DEDUCTIBLE The amount of out-of-pocket expenses that must be paid for health services by the insured before becoming payable by the carrier.

ELIGIBILITY Conditions that an associate must satisfy to participate in plan or obtain a benefit.

EMBEDDED DEDUCTIBLE Works like a traditional health plan deductible. Benefits begin for a single family member after either the members own expenses equal the individual deductible or the expenses from a combination of family members equal the family maximum.

FORMULARY A list containing the names of certain prescription drugs that a medical plan covers when dispensed to its member who have drug coverage.

GENERIC DRUGS: A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

IN-NETWORK Medical, dental and vision providers or facilities who have agreed to discounted fees with insurance carriers to participate within their provider networks.

INPATIENT A person who occupies a hospital bed, crib or bassinet while under observation, care, diagnosis or treatment for at least 24 hours.

MEDICAL GROUP (NETWORK) An organization of physicians who are generally located in the same facility or participate in a group network and provide services to covered individuals.

EXPLANATION OF BENEFITS (EOB): An explanation of benefits (EOB) is the insurance company's written explanation regarding a claim, showing what they paid and what the patient must pay.

MEMBER A person eligible to receive, or receiving, benefits from an insurance policy. Includes both those who have enrolled or subscribed and their eligible dependents.

NON-FORMULARY A drug or medication not listed and approved on a health insurance plan coverage schedule.

OUT-OF-NETWORK A healthcare provider with whom an insurance carrier does not have a contract to provide health care services. A member may pay higher copays, coinsurance and/or deductibles to see an out-of-network provider or have no coverage at all.

OUT-OF-POCKET MAXIMUM The maximum amount of expenses, as set by a health care plan that a person is obligated to pay directly during each calendar year.

OUTPATIENT A person who visits a clinic, emergency room or health facility and receives health care without being admitted as an overnight patient.

PRIMARY CARE PHYSICIAN (PCP) Provides treatments of routine illness and injuries and focuses on preventive health care. For members enrolled in an HMO Plan, a PCP will need to refer the member to a specialist.

PPO: Stands for Preferred Provider Organization which is a type of health plan that contracts with medical providers to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

PRE-EXISTING CONDITION: A health problem, like asthma, diabetes, or cancer, you had before the date that new coverage starts.

PREMIUM The amount of money an insurance company charges for insurance coverage.

View the full glossary of health insurance terminology at:
healthcare.gov/glossary/

CONTACT INFORMATION

Medical	Website / Email	Phone Number
Anthem Blue Cross PPO Personify Health Member Services/ Provider Finder	hconline.healthcomp.com	800-442-7247
SIMNSA HMO Cross-Border Provider Finder General Information	simnsa.com info@simnsa.com	619-407-4082
Express Scripts Prescription Drug RxBenefits Member Services Member Service Email	express-scripts.com customercare@rxbenefits.com	800-334-8134
Teladoc Talk to a doctor anytime 24/7	teladoc.com	800-Teladoc (835-2362)
Dental		
Western Dental DHMO Member Services General Information	westerndental.com customerservice@westerndental.com	800-992-3366
Superior Indemnity Dental Personify Health Member Services/Provider Finder	hconline.healthcomp.com	800-442-7247
Vision		
EyeMed Member Services	eyemed.com	866-800-5457
Life and AD&D		
Reliance Standard Questions and Forms	benefits@superiorm.com	442-341-7978
Employee Assistance Program (EAP)		
AllOne Health/Reliance Matrix Member Portal/Online Services	reliance-matrix.mylifeexpert.com	855-775-4357
Flexible Spending Accounts (FSA)		
Personify Health Questions and Forms	benefits@superiorm.com	442-341-7978
Profit Sharing and 401(k)		
Fidelity Investments Member Services/General Information	401k.com	800-835-5097
Your Benefits Advocate		
Email questions to	mybenefitsteam@alliant.com	

SUPERIOR QUALITY



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**GROW
WITH
US**

Love what you do and want others to know too? Follow us on Instagram, Facebook and LinkedIn and repost our content to your network. Better yet, tell your own stories by posting and tagging us.

