2025 EMPLOYEE BENEFITS GUIDE

SOUTHERN LAND COMPANY

Southern Land Company offers you and your eligible family members a comprehensive and valuable benefits program. This guide has been developed to assist you in learning about your benefit options and how to enroll. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

Welcome

TO SOUTHERN LAND COMPANY!

INSIDE THIS GUIDE

Questions?

If you have questions about your benefits, please contact the Benefits Member Advocacy Center ("Benefits MAC") at **800.563.9929** (Monday through Friday, 8:30 am to 5:00 pm ET) or go to **www.connerstrong.com/memberadvocacy**

Enrollment & Eligibility Information

Who is Eligible?

You are eligible to enroll in the Southern Land Company benefit plans if you are a full-time employee scheduled to work at least 30 hours per week. As a benefit-eligible employee, your benefits begin on the first day of the month following your date of hire. You may also cover your eligible dependents, including:

- Your legal spouse
- Your eligible child(ren) up to the end of the month in which they turn age 26 for medical, dental, and vision coverage. Children are defined as:
  * Your natural children, stepchildren, legally-adopted children, and children for whom you are the court-appointed legal guardian
  * Your Physically or mentally disabled children of any age who are incapable of self-support (proof of disability may be requested)

How to Enroll

The first step is to review your current benefits. Verify all of your personal information and make any necessary changes. Once all your information is up to date, it's time to make your benefit elections. It is important to weigh your options carefully. The decisions that you make during Open Enrollment will remain in place until the next Open Enrollment unless you experience a Qualifying Life Event.

When to Enroll

You will have 31 days from your date of hire to complete your benefits enrollment. If you enroll on time, coverage begins the first of the month following your date of hire.

If you do not enroll within your 31-day window, you will automatically be enrolled in company-sponsored benefits. You will have to wait until the next annual open enrollment to enroll in other benefits and/or make changes to your coverage.

Making Plan Changes During the Plan Year - Qualifying Life Events

Unless you experience a Qualifying Life Event, you cannot make changes to your benefits until the next Open Enrollment period. Qualifying Life Events include:

- Change in the number of eligible dependents due to birth, adoption, placement for adoption, or death
- Gain or loss of dependent status (i.e., your child reaches the age limit for eligibility)
- Change in legal marital status, including marriage, divorce, or death of a spouse
- Change in residence or workplace that changes you or your dependent's eligibility for coverage
- Change in employment status, such as starting or ending employment, for you, your spouse, or your children
- End of the maximum period for COBRA coverage
- Loss of other coverage

You must notify Human Resources within 31 days of experiencing a Qualifying Life Event.

Please Note: Changes to your HSA can be made at anytime or by pay period.

Medical Benefits

BCBST

Southern Land Company offers the following High Deductible Health Plan (HDHP) medical/prescription drug option, administered by Blue Cross Blue Shield of Tennessee (BCBST). The plan utilizes the two (2) BCBST provider networks, Select and Preferred. There are no differences in benefits between the networks, however, the participating providers differ between the networks. Employees who reside outside of Tennessee may only enroll in the Preferred network. To locate participating providers, visit **www.bcbst.com**.

MEDICAL PLAN

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Initial Deductible	$1,650 individual / $3,300 family	$1,650 individual / $3,300 family
Health Reimbursement Arrangement (Covers 75% of charges to full calendar year deductible)	$2,512.50 individual / $5,025 family	$2,512.50 individual / $5,025 family
Calendar Year Deductible	$5,000 individual / $10,000 family*	$10,000 individual / $20,000 family
Out-of-Pocket Maximum**	$5,000 individual / $10,000 family	$15,000 individual / $30,000 family
Preventive Care Services	Plan pays 100% NO deductible	Plan pays 80% NO deductible
Primary Care Physician (PCP) Required?	No	No
PCP Office Visit	Plan pays 100% after deductible	Plan pays 80% after deductible
Specialist Office Visit	Plan pays 100% after deductible	Plan pays 80% after deductible
Telemedicine (Teladoc)	Plan pays 100% after deductible	N/A
Urgent Care Center	Plan pays 100% after deductible	Plan pays 80% after deductible
Emergency Room (in-network and out-of-network covered at same benefit level)	Plan pays 100% after deductible	Plan pays 100% after deductible
Inpatient Hospital	Plan pays 100% after deductible	Plan pays 80% after deductible
Outpatient Surgery	Plan pays 100% after deductible	Plan pays 80% after deductible
Diagnostic Laboratory	Plan pays 100% after deductible	Plan pays 80% after deductible
Behavioral Health Inpatient/Outpatient	Plan pays 100% after deductible	Plan pays 80% after deductible
Skilled Nursing Facility & Rehabilitation Facility Services (Limited to 60 days combined per year)	Plan pays 100% after deductible	Plan pays 80% after deductible
Home Health Services	Plan pays 100% after deductible	Plan pays 80% after deductible
Ambulance	Plan pays 100% after deductible	Plan pays 100% after deductible
PRESCRIPTION DRUG BENEFITS	**RETAIL**	**MAIL ORDER**
Generic	Plan pays 100% after deductible	Plan pays 80% after deductible
Preferred Brand	Plan pays 100% after deductible	Plan pays 80% after deductible
Non-Preferred Brand	Plan pays 100% after deductible	Plan pays 80% after deductible
Specialty Medications	Plan pays 100% after deductible	Plan pays 80% after deductible

** If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.*

*** If you have other family members on the plan, they have to meet their own out-of-pocket maximum until the overall family out-of-pocket maximum has been met.*

Health Reimbursement Arrangement (HRA)

BCBST

A Health Reimbursement Arrangement (HRA) is an employer-funded account that is designed to pay for qualified healthcare expenses. The HRA works in conjunction with the medical plan and can be used to pay for out-of-pocket medical expenses incurred while you work to meet your plan deductible.

The HRA works in conjunction with the medical plan deductible. BCBST tracks your medical/prescription drug claim activity. Once you meet your initial deductible ($1,650 individual / $3,300 family), the HRA will reimburse 75% of eligible healthcare expenses. You are responsible for the remaining 25% of eligible healthcare expenses.

An advantage of an HRA is that it is employer-funded, which means tax-free money and a reduced annual deductible.

For Employee-Only Coverage: You will be responsible for the first $1,650 in out-of-pocket costs that will count toward the overall in-network plan deductible before funding from your HRA begins. The remaining in-network maximum out-of-pocket limit of $3,350 will be split between Southern Land Company (75%) and the employee (25%), reducing your overall out-of-pocket maximum to $2,487.50.

For Employee +1 and Family Coverage: You will be responsible for the first $3,300 in out-of-pocket costs that will count toward the overall in-network plan deductible before funding from your HRA begins. The remaining in-network maximum out-of-pocket limit of $6,700 will be split between Southern Land Company (75%) and the employee (25%), reducing your overall out-of-pocket maximum to $4,975.

Reimbursement Method: The BCBST HRA uses automatic reimbursements. Your network provider will submit a claim to BCBST for settlement and the plan will automatically reimburse the medical provider and pharmacies for any claims once your initial deductible has been met.

EMPLOYEE ONLY COVERAGE (IN-NETWORK)		
STEP #1	**STEP #2**	**STEP #3**
You pay $1,650 (Initial Deductible)	You pay $837.50 HRA pays $2,512.50	After $5,000 calendar year out-of-pocket maximum is met, Plan pays 100%
$1,650 + $837.50 + $2,512.50 = $5,000 (calendar year deductible)		

EMPLOYEE + 1 & FAMILY COVERAGE (IN-NETWORK)		
STEP #1	**STEP #2**	**STEP #3**
You pay $3,300 (Initial Deductible)	You pay $1,675 HRA pays $5,025	After $10,000 calendar year out-of-pocket maximum is met, Plan pays 100%
$3,300 + $1,675 + $5,025 = $10,000 (calendar year deductible)		

Prescription Drug

BCBST

Home Delivery

When you use the mail order program through BCBST for your maintenance medications, you can save money on your out-of-pocket prescription drug costs. You will receive up to a 90-day supply of medication delivered directly to your home.

To refill your prescription, please choose the method that works best for you. Have your Member ID card and the prescription number from a recent home delivery label or refill slip ready to help with the process.

Online: Go to **bcbst.com/rxplan**. Follow the directions to create a **caremark.com** account, or log in if you already have one.

* Choose **Prescriptions,** then **Start Rx Delivery** by Mail
* Fill out the form and enter your payment information

Phone: Call CVS Caremark at **1-844-740-0604**

Mail: Fill out a Home Delivery Refill Request Form at **bcbst.com/mail-order**, and mail it in to CVS Caremark, P.O. Box 659541, San Antonio, TX 78265.

GoodRx

Stop paying too much for your prescriptions! GoodRx is a prescription drug price comparison tool which allows you to easily search for retail pharmacies that offer the lowest price for specific medications.

The cost for the same medications - even when using a network retail pharmacy - varies drastically from one drug store to the next. While prescription drug plan copays may be the same no matter which pharmacy you go to, the retail costs to your employer may be greatly reduced when you get your medications from a pharmacy that charges a discounted price. Lower costs to your employer can also help keep your benefits costs down in the long run.

Use GoodRx to compare drug prices at local pharmacies and mail-order pharmacies and discover free coupons and savings tips. Find huge savings on drugs not covered by your insurance plan - you may even find savings versus your typical copay!

Learn more and start saving on your prescriptions today at **https://connerstrong.goodrx.com**.

PLEASE NOTE: When using GoodRx, your out-of-pocket costs are not processed through the pharmacy plan and DO NOT accumulate to your medical plan deductible and out-of-pocket maximum.

Dental Benefits

BCBST

Visit **www.bcbst.com/findadoctor** and login to locate an in-network provider, view your claims, manage your care and more!

PLEASE NOTE: *if you choose to use an out-of-network provider, you will be responsible for any billed charges that exceed the Maximum Allowable Charge (MAC).*

BASE PLAN

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible	$50 individual / $150 family	$50 individual / $150 family
Calendar Year Maximum (per patient)	$1,000	$1,000
Preventive & Diagnostic Services Exams, cleanings, X-rays, etc.	Plan pays 100% NO Deductible	Plan pays 100% NO Deductible
Basic Services Endodontics (root canal), periodontics, oral surgery	Plan pays 80%	Plan pays 80%
Major Services Major restorative, prosthodontics, implants	Plan pays 50%	Plan pays 50%
Orthodontia Benefits (Coverage for dependent children up to age 19 only)	50%	50%
Orthodontia Lifetime Maximum (per patient)	$1,000	$1,000

Did You Know...

Dental hygiene and oral health are directly linked to health in other areas of the body. Most people recognize the importance of maintaining good physical health, and having regular physical examinations, but we rarely extend the same consideration to our teeth. The trust is that good dental care is a crucial part of your overall physical health because other systems can be affected by your oral health. For example, taking proper care of your gums can help prevent heart disease.

Vision Benefits

VSP

Take care of your vision and overall health while saving on your eye care and eyewear needs. Vision insurance can help you maintain your vision as well as detect various health problems. Health conditions such as diabetes and high blood pressure can be detected early through a comprehensive eye exam.

	VSP VISION PLAN
BENEFITS	**IN-NETWORK**
Exam	$10 copay
Prescription Glasses	$25 copay
Lenses	
Single Vision	Included
Bifocal	Included
Trifocal	Included
Frames	$130 allowance
Contact Lenses	$130 allowance
Frequency	
Vision Exam	Every 12 months
Lenses	Every 12 months
Frames	Every 24 months
Contacts	Every 12 months

Remember! Using an out-of-network provider will be more costly. When using an in-network provider, you are maximizing your savings and benefits.

VSP Out-of-Network Benefits

When you use an in-network provider, you are guaranteed to save money. If you opt to use an out-of-network provider and have questions regarding your coverage, please call VSP Member Services via phone at **1-800-877-7195**.

When you use an out-of-network provider, you may submit a claim for reimbursement using an itemized receipt via your member portal at **www.vsp.com**, or your provider can submit the claim directly on your behalf.

VSP Vision Care App!

Scan the QR code below to download the VSP Vision Care App from the Apple App or Google Play Stores. Get instant access to your benefit coverage, Member ID Card, Exclusive Member Extras, and more.

Find a Provider

- Visit **www.vsp.com** and click **Find a Doctor**
- View a map and use the drop-pin functionality to find the right VSP network practice location for you. You can also filter by business hours or appointment availability.
- Look for the orange **Premier Program** banner to find a VSP network eye doctor that will help you maximize your savings.

The VSP Vision Care App offers easy navigation and a personalized dashboard, so you can get the benefit information you need, exactly when you need it.

Employee Contributions

PER 26 PAY PERIODS

Below are your per pay rates for the 2025 plan year.

MEDICAL/RX CONTRIBUTIONS

TIER	SELECT PLAN	PREFERRED PLAN	PREFERRED PLAN (NON-TN)
Employee	$42.19	$63.01	$53.78
Employee + Child(ren)	$223.45	$278.63	$255.55
Employee + Spouse	$246.53	$301.70	$278.63
Family	$281.14	$336.32	$313.24

DENTAL CONTRIBUTIONS

TIER	BASE DENTAL PLAN
Employee	$3.75
Employee + 1	$24.80
Family	$29.42

VISION CONTRIBUTIONS

TIER	VSP VISION PLAN
Employee	$3.21
Family	$6.89

Health Savings Account (HSA)

HEALTHEQUITY

If you participate in the HSA-Qualified HDHP, you may be eligible to participate in a Health Savings Account (HSA). An HSA is a tax-exempt savings account that can be used for contributions, earnings and withdrawals for eligible expenses.

HSA Highlights

- An HSA is portable, meaning that if you leave your employer, you can take your HSA funds with you.
- There is no “use it or lose it” provision with an HSA. If you don’t use the money in your account by the end of the year, funds stay there and collect interest on a tax-deferred basis.
- An HSA includes a banking partner that offers you several investment options that suit your needs.
- An HSA does not require third-party substantiation for transactions; however, you should keep records of these transactions in the event of an IRS audit.

HSA Eligibility

You may contribute to an HSA if you:

- Are covered under an HSA Qualified high deductible health plan (HDHP)
- Do not have disqualifying coverage such as other "first dollar" medical coverage etc.
- Are not eligible for or enrolled in Medicare
- Cannot be claimed as a dependent on someone else's tax return

HSA Eligible Expenses Include:

- Medical and prescription drug deductibles, coinsurance and copayments
- Dental deductibles, coinsurance and copayments
- Orthodontia or other dental care
- Eye exams, contact lenses and glasses

HSA Contributions

The maximum amount that can be contributed to the HSA in a tax year is established by the IRS and is dependent on whether you have individual or family coverage in the HDHP plan. For 2025, the contribution limits are:

- $4,300 for individual coverage
- $8,550 for family coverage
- The annual catch-up contribution for age 55 and older is $1,000

Health Savings Account (HSA) participants are urged to check their HSA election amount on an annual basis. Your pay period contributions will continue to be deducted from your paycheck unless you opt to make a change.

Please Note: You may make changes to your HSA anytime or on a per-pay basis.

Dependent Care and Commuter Reimbursement Account

Dependent Care Reimbursement Account with HealthEquity

A Dependent Care Reimbursement Account (DCRA) reimburses you for expenses that allow you and your spouse, if married, to work while your dependents are being cared for. Eligible employees may contribute up to $5,000 per year ($2,500 if married filing separately) to a Dependent Care Reimbursement Account to pay qualified dependent daycare expenses such as:

- The cost of child or adult dependent care
- The cost of an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

Please Note: You MUST re-enroll in this benefit every year.

Use-it-Or-Lose-It

This account operates under a use-it-or-lose-it rule, meaning that money that is not used by the end of the plan year does not roll over and must be forfeited, per the IRS regulations.

Commuter Reimburstment Account with Flores

This account allows you pay for eligible work-related transit and parking commuter expenses through pre-tax deductions from your paycheck. For the 2025 plan year you may contribute:

- **TRANSIT**: Up to $325 per month for transportation (mass transit, train, subway, bus fares, ferry rides). Transit requires payment with the Flores debit card.
- **PARKING**: Up to $325 per month for parking expenses incurred at or near your work location or near a location from which you commute using mass transit.

Your debit card is loaded with your pre-tax deductions each time a deduction is taken from your paycheck. Each time you use your debit card to pay for transit purchases, the funds are automatically debited from your transit account.

Enrollment should be done via Paycom ESS. Upon enrollment, please follow the steps below:

- Visit **www.flores247.com** or download the Flores mobile app
- Once you receive your PID (participant ID) notice, click "**Participant Login**", then "**First Time User**"
- Enter your PID
    - If you cannot locate your PID, enter your email address where it says, "**Resend PID# to Email Account on File**" and check your inbox
- Scroll down to enter your personal information and click "**Next**" and follow the instructions to access your online portal

Have Questions?

If you need additional information or have questions visit **www.southernlandbenefits.com/commuter** or contact Flores by calling **800.532.3327** or via web at **www.flores247.com**

Life and AD&D Benefits

PRUDENTIAL

Basic Life and AD&D Insurance

Life insurance can help provide for your loved ones if something were to happen to you. Southern Land Company provides full-time employees with 1 times annual earnings (minimum $50,000 and maximum $400,000) in Group Life and Accidental Death and Dismemberment (AD&D) insurance. Southern Land Company pays for the cost of this benefit. Employees will pay tax on premium amounts over $50,000. The benefit is paid to your beneficiaries in the event of your death. Benefits are reduced for eligible participants aged 65 and older.

While Southern Land Company offers Basic Life and AD&D insurance, some employees may be interested in additional coverage based on their personal circumstances. You may purchase Voluntary Life and AD&D insurance for yourself, spouse, and dependent child(ren) as outlined below. You are responsible for the full cost of coverage.

VOLUNTARY LIFE INSURANCE

BENEFIT DESCRIPTOIN	
Employee	5 times earnings up to $500,000
Spouse	Increments of $5,000 up to a maximum of 100% of employee election or $500,000
Dependent Child (Up to age 19 or age 26 if full-time student)	Increments of $2,000 up to a maximum of $10,000 (minimum election amount is $2,000)
GUARANTEED ISSUE* AMOUNTS	
Employee	$150,000
Spouse (Under age 70)	$25,000

*Evidence of Insurability (EOI)

EOI is required if:

- You would like to increase your current coverage.
- You waived coverage when you initially became eligible to enroll.
- You are a new hire and wish to elect coverage over $150,000 (guaranteed issue).

Eligible employees who waived coverage when they initially became eligible, can elect the minimum of $10k in coverage. This locks you into the plan. Please note, Evidence of Insurability (EOI) is required for employees who initially waived coverage and chose to elect the minimum of $10k.

- For subsequent enrollments, if you need more coverage, you can increase by up to $50k per year, not to exceed the overall guaranteed issue of $150k, without having to complete EOI.
- If you become completely uninsurable, the lock-in feature will allow you to elect additional coverage.

Short and Long Term Disability

PRUDENTIAL

Short-Term Disability (STD)

Short-Term Disability (STD) is a type of disability insurance coverage that can help you remain financially stable should you become injured or ill and cannot work. You may receive 100% of your salary for up to 11 weeks. Please contact Human Resources for more information, as this benefit is self-administered by the company.

Long-Term Disability (LTD)

Long-Term Disability (LTD) insurance protects employees in the event they become disabled for a prolonged period prior to retirement.

Southern Land Company provides you with LTD in the event your illness or injury lasts beyond 90 days. This helps ensure you have a continued income if you are unable to work due to a covered sickness or injury. The duration of benefits may last up to Social Security Normal Retirement Age (SSNRA), depending on the severity of your disability. You will pay tax on the premium so that you receive the benefit tax-free. You may receive 60% of your pre-disability earnings to a maximum monthly benefit of:

- **Staff**: $7,500
- **Senior Management**: $20,000
- **Executives**: $20,000

Benefits are reduced for eligible participants age 65 and older.

Employee Assistance Program (EAP)

GUIDANCE RESOURCES

There are times when you cannot do it alone. With GuidanceResources you don't have to.

Sometimes we experience difficulties that cannot be resolved without the assistance of a trained professional. Unresolved issues with substance abuse, stress, anxiety, home life, and work life can affect or undermine our quality of life.

With an EAP, you and your family members have access to free, confidential resources to help handle life's everyday - and not so everyday - challenges.

How the EAP Works

The EAP provides eligible employees and their dependents assistance with behavioral healthcare services that can help begin the process of resolving emotional or substance abuse issues. You and your dependents are entitled to **six (6) face-to-face or telephonic sessions per year**. The encounter with the counselor through the EAP is completely **confidential.**

Contact GuidanceResources

For personal and confidential assistance, call **800.311.4327** or visit **www.guidanceresources.com** and enter the Web ID: **GEN311**. Help is available 24/7.

GuidanceResources can help you through uncertain times, by acting as your advocate whenever you or your dependents need treatment for the following:

- Emotional Difficulties/Depression
- Family/Relationship Problems
- Stress/Anxiety Issues
- Grief and Loss Issues
- Alcohol/Drug Abuse or Addiction
- Anger/Rage Issues
- Eating Disorders
- Life Transition Problems
- Gambling Problems
- Other Behavioral Addictions

GuidanceResources can also assist with legal consultations, financial advice, contract review, real estate transactions and more!

Identity Theft Protection

ALLSTATE

Southern Land Company partners with Allstate to provide you with the opportunity to purchase Identity Theft Protection for you and your family. You have the option of purchasing either the Pro+ Plan or the Pro+ Cyber Plan. Here are some of the features Allstate offers with these plans:

Reimbursement

If you fall victim to fraud, Allstate will reimburse your out-of-pocket costs and up to $1 million in stolen funds from accounts such as your 401(k), or tax returns.

Comprehensive monitoring and alerts

A proprietary monitoring platform that detects high-risk activity to provide rapid alerts at the first sign of fraud, so you can detect fraud at its earliest sign, enabling quick restoration for minimal damage and stress.

High-risk transaction monitoring

Allstate will send alerts for non-credit-based transactions like student loan activity and medical billing.

Account activity

You're alerted when unusual activity on your personal banking accounts could be a sign of account takeover.

Financial activity monitoring

Alerts triggered from sources such as bank accounts, thresholds, credit and debit cards, 401(k)s, and other investment accounts help you take control of your finances.

Social media monitoring

Monitor social accounts for everyone in your family, with monitoring for vulgarity, threats, explicit content, violence, and cyberbullying. You can even add your YouTube accounts and Allstate will monitor comments for questionable content.

Dark web monitoring

In-depth monitoring goes beyond just looking out for a participant's social security number. Bots and human intelligence scour closed hacker forums for compromised credentials and other personal information. You will be immediately alerted if you have been compromised.

The Pro+ Cyber plan also includes protection for webcams, phishing, VPN's, firewalls and network security. When you elect family coverage, you will also receive a $2 million restoration limit versus $1 million restoration limit for the Pro+ plan.

TIER	PRO+ PLAN (PER MONTH RATE)	PRO+ CYBER PLAN (PER MONTH RATE)
Employee Only	$9.95	$11.95
Family*	$17.95	$20.95

**Family includes employee, spouse, kids of all ages, any dependent living within employee's household, deceased family members and any family member aged 65 or older (regardless if they live with the employee).*

Have Questions?

For more information, call **800.789.2720** or email **customercare@aip.com**.

Pet Insurance

LIBERTY MUTUAL

Pet Insurance can help your pet get the best veterinary care available when they need it by reducing the financial burden of unexpected medical costs due to illness or injuries. Plus, preventive wellness options could help you stay ahead of any potential issues altogether.

Product Details

Eligibility

- Dogs: Age minimum of 8 weeks old
- Cats: Age minimum of 8 weeks old

Reimbursement

- Depending on your policy, you are reimbursed up to a certain percent of your out-of-pocket cost up to your annual maximum

Underwriting

- Simplified issue
- Pre-existing conditions reviewed at time of claim

Exclusions

- Pre-existing conditions
- Breeding/Pregnancy
- Organ & Tissue transplants
- Professional or Commercial use
- Unlawful Acts
- Experimental & Investigations

Sign up by calling **844.250.9199** or visiting **https://pet.libertymutual.com/**

Policy Options

Liberty Mutual offers customizable policies so employees only pay for what they need. With multiple policy options, plus the ability to select reimbursement payout, deductible, and annual maximum, employees can get the best policy to protect their pet and their wallets.

Accident

- Accidental injuries (including to permanent teeth)
- Euthanasia or anesthesia
- Cremation and burial expenses
- Ingestion of a foreign object (up to two treatments max per policy year)
- Accidental death

Accident & Illness

Everything covered under the Accident policy, plus:

- Illnesses (e.g., cancer, influenza, and kennel cough)
- Alternative medicine
- Behavioral therapy
- Hereditary and congenital conditions

Accident, Illness & Wellness

Everything covered under the Accident & Illness policy, plus fix payment amounts for the following (not subject to deductible and annual maximum)

- Wellness exams
- Intestinal deworming
- Routine dental cleaning
- Spaying/neutering
- Flea and tick protection

Choose from these options:

- Reimbursement: 70%, 80%, or 90%
- Deductible: $250, $500, or $1K
- Annual Maximum: $5K, $10K, or $15K

Employee Resources

CONNER STRONG & BUCKELEW

Benefits Member Advocacy Center

Don't get lost in a sea of benefits confusion! With just one call or click, the Benefits MAC can help guide the way!

The Benefits Member Advocacy Center ("Benefits MAC") provided through our relationship with Conner Strong & Buckelew, can help you and your covered family members navigate your benefits. Contact the Benefits MAC to:

- Find answers to your benefits questions
- Search for participating network providers
- Clarify information received from a provider or your insurance company, such as a bill, claim, or explanation of benefits (EOB)
- Rescue you from a benefits problem you've been working on
- Discover all that your benefit plans have to offer!

You can contact the Benefits MAC in any of the following ways:

- Via phone: **800.563.9929**, Monday through Friday, 8:30 am to 5:00 pm ET
- Via web: **www.connerstrong.com/memberadvocacy**
- Via e-mail: **cssteam@connerstrong.com**

Member Advocates are available Monday through Friday, 8:30 am to 5:00 pm ET. After hours, you will be able to leave a message with a live representative and receive a response by phone or email during business hours within 24 to 48 hours of your inquiry.

BenePortal

Your Benefits Information - All in One Place!

Southern Land Company employees have access to a full-range of valuable employee benefit programs. With BenePortal, you and your dependents can review your current employee benefit plan options online, 24/7.

Use BenePortal to access benefit plan documents, insurance carrier contacts, forms, guides, links and other applicable benefit materials. BenePortal is mobile-optimized, making it easy to view your benefits on-the-go. Simply bookmark the site in your phone's browser or save it to your home screen for quick access.

BenePortal features include:

- Secure online access - no login required
- Direct links to benefits enrollment sites
- Plan summaries
- Wellness resources
- Carrier contacts
- Downloadable forms
- GoodRx
- Benefit Perks Discount Program
- And more!

Simply to go **www.southernlandbenefits.com** to access your benefits information today!

Scan the QR Code with your mobile device to instantly access BenePortal!

Value-Added Services

Benefit Perks

This feature provides a broad array of services, discounts and special deals on consumer services, travel services, recreational services and much more! To begin using now, access the site and register.

Learn more at:
https://connerstrong.corestream.com

HUSK Marketplace

Achieving optimal health and wellness doesn't have to be complicated or expensive. Access exclusive best-in-class pricing with some of the biggest brands in fitness, nutrition, and wellness with HUSK Marketplace.

Visit: **https://marketplace.huskwellness.com/connerstrong**

HealthyLearn

This resource covers over a thousand health and wellness topics in a simple, straight-forward manner. The HealthyLearn On-Demand Library features all the health information you need to be well and stay well.

Learn more at:
https://healthylearn.com/connerstrong

Carrier Contacts

COVERAGE TYPE	CARRIER NAME/CONTACT	PHONE NUMBER	WEBSITE/EMAIL
Medical/Prescription/Health Reimbursement Account/Dental	Blue Cross Blue Shield of Tennessee (BCBST)	800-565-9140	www.bcbst.com
Telemedicine	Teladoc	800-835-2362	www.bcbst.com/Teladoc
Vision	VSP	800-877-7195	www.vsp.com
Health Savings Account	HealthEquity	866-346-5800	www.healthequity.com
Dependent Care Reimbursement Account	HealthEquity	877-924-3967	www.healthequity.com
Basic Life/AD&D/Long-Term Disability	Prudential	Life Insurance Claims: 800-524-0542 Disability Claims: 800-842-1718	www.prudential.com
Short-Term Disability	Southern Land Company	615-778-3151	becca.reilly@southernland.com
Employee Assistance Program	GuidanceResources	800-311-4327	www.guidanceresources.com (Web ID: **GEN311**)
Identity Theft Protection	Allstate	800-789-2720	customercare@aip.com
Pet Insurance	Liberty Mutual	844-250-9199	https://pet.libertymutual.com/southernland (Promo Code: **southernland**)
Benefits Member Advocacy Center	Conner Strong & Buckelew	800-563-9929	www.connerstrong.com/memberadvocacy

Legal Notices

Eligibility

An eligible employee with respect to the programs described in this Guide is any individual who is designated as eligible to participate in and receive benefits under one or more of the component benefit programs described herein. The eligibility and participation requirements may vary depending on the particular component program. You must satisfy the eligibility requirements under a particular component benefit program in order to receive benefits under that program. Certain individuals related to you, such as a spouse or your dependents, may be eligible for coverage under certain component benefit programs. To determine whether you or your family members are eligible to participate in a component benefit program, please read the eligibility information contained in the Plan Document for the applicable component benefit programs.

HIPAA Special Enrollment Notice

Loss of other coverage (excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage (including COBRA coverage) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage.

Loss of eligibility for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or CHIP. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

New dependent by marriage, birth, adoption, or placement for adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For a new dependent as a result of marriage, coverage will be effective the first of the month following your request for enrollment.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

To request special enrollment or obtain more information, contact HR

Newborns' and Mothers' Health Protection Act Notice

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, [or midwife], or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

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 deductible, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact your medical plan administrator.

Important Notice From Southern Land Company, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Southern Land Company, Inc. 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:

- 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.
- BlueCross BlueShield of TN (BCBST) has determined that the prescription drug coverage offered by Southern Land Company is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current plan with BCBST will not be affected. If you do decide to join a Medicare drug plan and drop your current BCBSKC plan coverage, be aware that you and your dependents may not be able to get this coverage back until next open enrollment.

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 BCBST 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.

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

Date:	September 2024
Name of Entity/Sender:	Southern Land Company
Contact-Position/Office:	Becca Reilly, HR Director
Address:	3990 Hillsboro Pike, Suite 400
	Nashville, TN 37215
Phone:	615-778-3151 |
Email:	becca.reilly@southernland.com

Availability of Summary Health Information
As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. The SBC is available on the web at: www.southernlandbenefits.com. A paper copy is also available, free of charge, by contacting Human Resources.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace.

For more information, visit www.healthcare.gov.

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - MEDICAID
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

Legal Notices

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid Website: https://www.in.gov/medicaid/
http://www.in.gov/fss/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: www.mymaineconnection.gob/benefits/s/?language=en_US
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-495-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: https://www.pa.gov/en/agencies/dhs/resources/chip.html
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA - Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS - Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-562-3022

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: http://mywvhipp.com/ and https://dhhr.wv.gov/bms/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

Legal Notices

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Summaries of Benefits and Coverage
The government-required Summaries of Benefits and Coverage (SBCs), which summarize important information about your Blue Cross Blue Shield of Tennessee medical plan options, are available on our intranet as well as in your member portal at www.bcbst.com. A paper copy is also available upon request.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) COBRA Continuation Coverage General Notice
You're getting this notice because you recently gained coverage under the Southern Land Company health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice 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. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What Is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose coverage under the Plan because of the following qualifying events:

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

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

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

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Southern Land Company's Human Resources Department. For additional information procedures and required information/documentation, please contact Human Resources.

How is COBRA Continuation Coverage Provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

Disability Extension of 18-Month Period of Continuation Coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Legal Notices

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period1 to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

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

Plan Contact Information:

Date: January 1, 2025
Southern Land Company
Becca Reilly, HR Director
3990 Hillsboro Pike, Suite 400, Nashville, TN 37215
Ph: 615-778-3151 | Email: becca.reilly@southernland.com

Model Disclosure Notice Regarding Patient Protections Against Surprise Billing Instructions for Group Health Plans and Health Insurance Issuers (For use for plan years beginning on or after January 1, 2023)

Federal law requires group health plans and health insurance issuers offering group or individual health insurance coverage to make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 9816 of the Internal Revenue Code (the Code), section 716 of the Employee Retirement Income Security Act (ERISA), and section 2799A-1 of the Public Health Service Act (PHS Act) apply, information in plain language on:

1. the federal restrictions on balance billing in certain circumstances,
2. any applicable state law protections against balance billing,
3. the requirements under Code section 9816, ERISA section 716, and PHS Act section 2799A-1, and
4. information on contacting appropriate state and federal agencies if an individual believes a provider or facility has violated the restrictions against balance billing.

Plans and issuers can, but aren't required to, use this model notice to meet these disclosure requirements. To use this document properly, the plan or issuer should review, complete, and provide it in a manner consistent with applicable state and federal law. The Departments of Health and Human Services, Labor, and the Treasury (the Departments) consider use of this model notice, in accordance with these instructions, to be good faith compliance with the disclosure requirements of section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, if all other applicable requirements are met.

If a state develops model or required language for its disclosure notice that is consistent with section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, the Departments will consider a plan or issuer that makes good faith use of the state-developed language compliant with the federal requirement to include information about state law protections.

Language access

Compliance with Federal Civil Rights Laws

Entities that get federal financial assistance must comply with federal civil rights laws that prohibit discrimination. These laws include section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, and section 504 of the Rehabilitation Act of 1973. Section 1557 and title VI require covered entities to take reasonable steps to ensure meaningful access to individuals with limited English proficiency, which may include offering language assistance services such as translation of written content into languages other than English.

Sections 1557 and 504 require covered entities to take appropriate steps to ensure effective communication with individuals with disabilities, including provision of appropriate auxiliary aids and services. Auxiliary aids and services may include interpreters, large print materials, accessible information and communication technology, open and closed captioning, and other aids or services for persons who are blind or have low vision, or who are deaf or hard of hearing. Information provided through information and communication technology also must be accessible to individuals with disabilities, unless certain exceptions apply. Plans and issuers are reminded that the disclosure notice must comply with applicable state or federal language-access standards.

Use of Plain Language

Plans and issuers are encouraged to use plain language in the disclosure notice and test the notice for clarity and usability when possible. Plain language, accessibility, and language access resources:

- Plainlanguage.gov/guidelines
- Section508.gov
- LEP.gov

NOTE: The information provided in these instructions is intended to be only a general summary of technical legal standards. It isn't intended to take the place of the statutes, regulations, or formal policy guidance on which it is based. Refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

DON'T INCLUDE THESE INSTRUCTIONS WITH THE DISCLOSURE NOTICE GIVEN TO PARTICIPANTS, BENEFICIARIES, OR ENROLLEES.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1401. The time required to complete this information collection is estimated to average 3.5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments

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concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26- 05, Baltimore, Maryland 21244-1850.

Your Rights and Protections Against Surprise Medical Bills

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

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

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

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

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

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

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

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

When balance billing isn't allowed, you also have these protections:
- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  * Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  * Cover emergency services by out-of-network providers.
  * Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  * Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, the federal phone number for information and complaints: 1-800-985-3059.

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

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PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.

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

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

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15. Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan. There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage. Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/gettingmedicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area

PART B: Information about Health Coverage Offered by Your Employer

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

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3. Employer Name Redwood-SLC Holdings, LLC.		4. Employer Identification number (EIN) 86-3529899
5. Employer Address 3990 Hillsboro Pike, Suite 400		6. Employer Phone Number 615-778-3151
7. City Nashville	8. State TN	9. Zip Code 37215
10. Who can we contact about your employee health coverage at this job Becca Reily, Senior Director, People & Culture		
11. Phone Number (if not different from above)		12. Email Address becca.reily@southernland.com

An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

SOUTHERN LAND COMPANY

Southern Land Company reserves the right to modify, amend, suspend or terminate any plan, in whole or in part, at any time. The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. If you have any questions about your Guide, contact Human Resources.