A Guide to Your 2022 Benefits

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DOWN TO EARTH

LANDSCAPE & IRRIGATION

What's New for the 2022 Plan Year?

Down to Earth offers a comprehensive suite of benefits to promote health and financial security for you and your family. This booklet provides you with a summary of your benefits. Please review it carefully so you can choose the coverage that's right for you.

Benefits Enrollment Website

- View your information on www.dtebenefits.com
- Enroll and view your benefits
- Update dependents & emergency contact

See Enrollment instructions on page 21

Online access to the 2022 Down to Earth benefits guide through Flipbook and online resources through the Mobile Wallet. ***View information from your computer or cell phone!***

DTE I Care Foundation

NEW!

Down to Earth has created the DTE I Care fund to help our valued team members during times of personal crisis. This fund is made of donations from team members and contributions from the company. Contributions are tax deductible and can be made weekly via payroll deductions or directly to the fund by check.

See page 9 for details

Aetna Medical Benefits

NEW!

We're introducing a Health Savings Account (HSA) option to the Aetna OA 5500 High Deductible Health Plan. This account allows you to save up to $3,600 towards your medical costs before taxes. At the end of each quarter, enrollees who are contributing to the HSA will receive a fixed employer contribution towards their HSA!

Medical rates will be increasing and to help reduce costs we will be making some changes to the plans we offer.

The Aetna OA 1500 plan is being replaced with the Aetna OA 3500 plan – enrollees will automatically be moved to the new plan during Open Enrollment.

The Aetna OA 5000 plan is being removed – enrollees will automatically be moved to the Aetna OA 5500 plan during Open Enrollment.

See pages 4 – 5 for details

Benefit Basics

As a Down to Earth employee, you are eligible for benefits following the applicable waiting period. Your applicable waiting period can be found in the plan certificates.

You may enroll your eligible dependents for coverage once you are eligible. Your eligible dependents include:

- Your legal spouse
- Your children up to age 26

Once your benefit elections become effective, they remain in effect until the end of the year. You may only change coverage within 30 days of a qualified life event.

Qualified Life Events

Generally, you may change your benefit elections only during the annual enrollment period. However, you may change your benefit elections during the year if you experience a qualified life event, including:

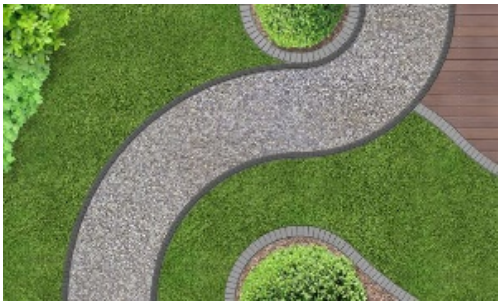
- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse or dependent child
- Adoption of or placement for adoption of your child
- Change in employment status of employee, spouse or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage
- Entitlement to Medicare or Medicaid

Teladoc®

Aetna provides access to medical services thru Teladoc®. This means you can receive virtual, on-demand medical treatment in the comfort of your home.

You must notify Human Resources within 30 days of the qualified life event. Depending on the type of event, you may be asked to provide proof of the event. If you do not contact Human Resources within 30 days of the qualified event, you will have to wait until the next annual enrollment period to make changes (unless you experience another qualified life event).

For more information email Benefits@down2earthinc.com



Cost of Your Benefits

The Company pays the full cost of many of your benefits; you share the cost for others. You pay the full cost for any voluntary benefits you elect.

Benefit	Tax Treatment	Who Pays
Medical Coverage	Pretax	The Company & You
HSA Coverage	Pretax	The Company & You
Dental Coverage	Pretax	The Company & You
Vision Coverage	Pretax	The Company & You
Accident Voluntary Insurance	After-tax	You
Critical Illness Voluntary Insurance	After-tax	You
Supplemental Life and Accidental Death & Dismemberment (AD&D) Insurance	After-tax	You
Disability Coverage Voluntary Insurance	After-tax	You
Hospital Insurance	After-tax	You
401(k) Retirement Savings Plan	Pretax	The Company & You

Medical Coverage

Down to Earth offers a choice of medical plan options so you can choose the plan that best meets your needs – and those of your family. Each plan includes comprehensive health care benefits, including free preventive care services and coverage for prescription drugs.

Plan Provisions	AETNA OA 5500 with HSA*		AETNA OA 3500**	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual deductible Individual / Family	$5,500 $11,000	$14,000 $28,000	$3,500 $7,000	$9,000 $18,000
Out-of-pocket maximum (Includes deductible)	$6,900 $13,800	$24,000 $48,000	$6,600 $13,200	$18,000 $36,000
Coinsurance - Amount you pay after deductible	30%	50%	20%	50%
Preventive care	100%	Ded then 50%	100%	Ded then 50%
Primary physician office visit	Ded then 30%	Ded then 50%	$25	Ded then 50%
Specialist office visit	Ded then 30%	Ded then 50%	$75	Ded then 50%
Hospital services	Ded then 30%	Ded then 50%	Ded then 20%	Ded then 50%
Urgent care	Ded then 30%	Ded then 50%	$50	Ded then 50%
Emergency room care	Ded then 30%	Ded then 30%	$500	$500
Retail prescription drugs (30-day supply) Generic/Formulary/ Non-Formulary/Specialty	$10/$50/$80/30% to $250 max	Applicable copay then 50% of submitted cost	$10/$45/$70/30% to $250 max	Applicable copay then 50% of submitted cost
Mail Order prescriptions (90-day supply) Generic/Formulary/ Non-Formulary	$20/$100/$160	n/a	$20/$90/$140	n/a

***For the $5500 plan, all Medical/Rx payments apply to deductible before any coinsurance applies**
****For the $3500 plan, all Rx payments apply to deductible before any copays apply**

Coverage Levels	WEEKLY PRE-TAX PREMIUM AMOUNTS	
	AETNA OA 5500 with HSA	AETNA OA 3500
Employee	$43.45	$60.46
Employee & Spouse	$180.22	$246.41
Employee & Child(ren)	$126.75	$173.72
Employee & Family	$253.51	$346.04

Health Savings Account

A Health Savings Account (HSA) is a savings account that belongs to you that is paired with the Aetna OA 5500 plan. It allows you to make tax-free contributions to a savings account to pay for current and future medical expenses for you and your dependents.

Start It

- Contributions to the HSA are tax-free for you.
- Plans with an HSA typically cost less than other plans so the money you save on premiums can be put into your HSA. You save money on taxes and have more flexibility and control over your health care dollars.

Build It

- All of the money in your HSA is yours even if you leave your job, change plans or retire.
- In 2021, the total of your contributions can be up to $3,600 for individual coverage and $7,200 for family coverage.
- In 2022, the total of your contributions can be up to $3,650 for individual coverage and $7,300 for family coverage.

Use It

- You can withdraw your money tax-free at any time, as you use it for qualified expenses (a list can be found on www.irs.gov).
- You can also save this money and hold onto it for future eligible health care expenses.

Grow It

- Unused money in your HSA will roll over, earn interest and grow tax-free over time.
- You decide how to use the HSA money, including whether to save it or spend it for eligible expenses. When your balance is large enough, you can invest it — tax-free.

Eligibility Details

- If you are age 55 or older, you can contribute an additional $1,000 per year.
- You are not allowed to be enrolled in any other health coverage, and cannot have an HSA if you are enrolled in any other health coverage or Medicare, or claimed as a dependent on someone else's tax return.

Quarterly Company Contributions

- For the 2022 plan year, Down to Earth will provide a quarterly contribution of $50 for individual coverage and $100 for family coverage
- Employees must be enrolled in the HSA and actively contributing to the account in order to receive the quarterly company contributions
- Contribution months fall in January, April, July and October
- Please be aware that company contributions count towards the annual allowable max:
  - **In 2021, the total of your contributions can be up to $3,600 for individual coverage and $7,200 for family coverage.**
  - **In 2022, the total of your contributions can be up to $3,650 for individual coverage and $7,300 for family coverage.**

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Dental Coverage

Regular dental exams can help you and your dentist detect problems in the early stages when treatment is simpler, and costs are lower. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease and is an important part of maintaining your medical health. The Company offers you a choice of 2 dental plans.

Plan Provision	Option 1: Unum High PPO	Option 2: Unum Base PPO
Annual deductible (Individual/family)	$50 Annual Maximum 3 Per Family	$50 Annual Maximum 3 Per Family
Annual maximum per person	$1,500	$1,000
Carry-Over benefit maximum*	$1,250	$1,000
Diagnostic and preventive care: Includes cleanings, fluoride treatments, sealants and x-rays	100%, no deductible	100%, no deductible
Basic services: Includes fillings, periodontics, scaling and root planning, and oral surgery	80% after deductible	80% after deductible
Major services: Includes crowns, bridges and full and partial dentures	50% after deductible	50% after deductible
Orthodontia Dependent child (up to age 25) and adult coverage	50% after deductible Lifetime max of $1,500	N/A
Weekly Pre-tax Premium		
Employee	$4.82	$2.92
Employee + Spouse	$9.81	$5.94
Employee + Child(ren)	$11.41	$6.91
Employee + Family	$16.38	$9.92

*Both plan options include a carry-over benefit. During each benefit year, if you receive at least one cleaning, one regular exam, and your total dental claims are below the threshold limit, a portion of the annual maximum will automatically carry over to the next year.

Vision Coverage

The vision plan covers routine eye exams and pays for all or a portion of the cost of glasses or contact lenses if you need them.

Plan Provision	EyeMed In-Network	EyeMed Out of Network
Exam	$10 copay	Max reimbursement up to $40
Frequency ▪ Exam ▪ Lenses or Contacts ▪ Frames	Once every 12 months	Once every 12 months
Frames	$150 retail allowance 20% off any amount over $150	Max reimbursement up to $105
Lenses ▪ Single Vision Lenses ▪ Bifocal Lenses ▪ Trifocal Lenses	$25 copay	Up to $30 Up to $50 Up to $70
Medically Necessary Contact Lenses	Covered	Up to $210
Weekly Pre-tax Premium		
Employee	$1.36	
Employee + Spouse	$2.72	
Employee + Child(ren)	$2.99	
Employee + Family	$4.34	

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Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance Coverage

- Life insurance is an important part of your financial security, especially if others depend on you for support.
- Accidental Death & Dismemberment (AD&D) insurance is designed to provide a benefit in the event of accidental death or dismemberment.
- Employees can elect from $10,000 to the lesser of 5x annual earnings or $500,000. Employees must be actively at work to enroll in coverage.
- Employees and dependents currently enrolled in coverage may increase their coverage amount up to the guaranteed issue (GI) amount without having to answer medical questions.
- If you or your dependent had previously waived coverage, you will be required to submit an Evidence of Insurability (EOI) form for any coverage amount

Access the Benefits System for Voluntary Life/AD&D Rates

Hospital Indemnity Insurance

Hospital insurance is designed to help provide financial protection for covered individuals by paying a benefit due to a hospitalization. Employees can use the lump sum benefit to meet the out-of-pocket expenses and extra bills that can occur. This is a voluntary, 100% employee paid product.

TIER	WEEKLY RATE
Employee Only	$4.56
Employee & Spouse	$10.76
Employee & Child(ren)	$7.16
Family	$13.36

Accident Insurance Coverage

Accident Insurance covers you in the event of a covered accident such as falling. This coverage pays benefits whether your covered accident happens at work, at home or away.

- 24-hour protection
- Covers related expenses such as lost income, childcare, deductibles & copays
- Wellness-screening benefit paid direct to you each year

TIER	WEEKLY RATE
Employee Only	$2.95
Employee & Spouse	$5.24
Employee & Child(ren)	$6.64
Family	$8.94

Critical Illness Insurance Coverage

The Critical Illness insurance helps offset the financial effects of a catastrophic illness by paying a lump sum benefit when employees or their family members are diagnosed with a covered illness. You can receive a cash benefit to help pay unexpected costs not covered by your health plan.

- Employees can choose coverage amounts of $10,000 to $30,000 in $5,000 increments as applied for by the employee and approved by Unum
- Child coverage automatically included with Employee coverage. Children automatically covered at 50% of employee amount.
- Employee must be covered for Critical Illness in order to insure their spouse for Critical Illness. Spouse coverage amount is 50% of Employee coverage amount.

Access the Benefits System for Critical Illness Rates

Disability Insurance Coverage

RELIANCE STANDARD LIFE INSURANCE COMPANY

Eligibility: Active full-time management & salaried employees

The goal of the Company's Disability Insurance Plans is to provide you with income replacement should you become disabled and unable to work due to a non-work-related illness or injury. This benefit is available to management & salaried employees only. Disability insurance is 100% voluntary and coverage is paid by the employee.

Short-Term Disability (STD)

- Covers 60% of your weekly pre-disability earnings — up to a $2,500 weekly maximum
- Benefits begin on the first day of injury or eighth day of illness and continue to the earlier of recovery or 11 weeks

STD Features

- ✓ Maternity covered as any other illness
- ✓ Military services LOA continuation
- ✓ Partial disability benefit

Long-Term Disability (LTD)

- Covers 60% of your weekly pre-disability earnings — up to a $12,000 monthly maximum.
- Benefits begin after ninety days of total disability and will not extend beyond the longer of Social Security Normal Retirement Age or Duration of Benefits outlined in the plan booklet.

LTD Features

- ✓ Extended disability benefit
- ✓ Work incentive and childcare provisions
- ✓ Residual and partial disability benefit

401(k) Retirement Savings Plan

The Down to Earth 401(k) Retirement Savings Plan offers a convenient way to save for your future through payroll deductions.

Eligibility

You are eligible to participate in the plan as of the first day of the quarter following 6 months of service with the Company.

Employee Contributions

Contributions from your pay are made on a pretax basis or post-tax Roth — up to the IRS annual limit. If you are 50 years of age or older, (or if you will reach age 50 by the end of the year), you may make a catch-up contribution in addition to the normal IRS annual limit.

Vesting

Employee 401 (k) deferrals and Safe Harbor contributions are always 100% vested.

For More Information

For additional details about the 401(k) Retirement Savings Plan or to enroll or change your contribution rates or investment elections, contact Benefits@down2earthinc.com

AMERICAN FUNDS®
From Capital Group

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OUR I CARE VALUES

Integrity: We act with honesty, transparency, and reliability, always doing what is right for our customers, our environment and our teams.

Community: We are one team that respects and cares for each other, continuously striving to beautify and improve the communities we serve.

Accountable: We meet our commitments to each other and to our valued customers and act if we fall short of expectations.

Relentless: We are constant in our efforts to provide solutions to customers and to satisfy their needs.

Excellence: We strive to deliver best-in-class quality and safety while improving our services and results every day.

DTE I Care Fund

HOW TO APPLY FOR FUNDS:

Call Helping Hands™ at 706.754.6884 (Mention you are with Down To Earth)

**You must meet the grant guidelines and criteria to be eligible to receive money from the DTE I Care Fund.*

We have created the Down To Earth I Care fund to help our valued team members during times of personal crisis. This fund is made of donations from team members and contributions from the company.

A grant up to $1,000 can be given to a team member to help cover funeral expenses or a home catastrophe. It could also match up to $500 for money raised by our employees for their team member in need.

CONTRIBUTE TO THE DTE I CARE FUND TODAY!

Contributions are tax deductible and can be made weekly via payroll deduction or directly to the fund by check sent to Provision Bridge, PO Box 157, Tallulah Falls, GA 30573
(*Note: Down to Earth I Care Fund—Fund #16085 on the memo*)

For Payroll deductions you can sign up to contribute to the DTE I Care fund through the benefits enrollment system during your new hire period, and annually during the open enrollment period. Throughout the year, you can send an email to ICARE@down2earthinc.com to request a contribution start/stop.

The DTE I Care Fund is a 501(c)3 charitable foundation made possible through ProvisionBridge and Helping Hands™

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Family Medical Leave Act

The Family and Medical Leave Act of 1993 (FMLA) was designed to provide eligible employees with up to 12 workweeks per year of job-protected leave to address critical personal and family matters. It is the policy of Seasons Service Select, LLC and its subsidiaries (the "Company" or "employer") to provide eligible employees with leave of absence in accordance with the provisions of FMLA.

FMLA also allows for up to 26 weeks of unpaid leave in a single 12-month period for qualified employees caring for a military servicemember or veteran.

You are eligible for an FMLA leave of absence under the company's policy if you meet the following requirements:

- You have completed at least 12 months of employment
- You have worked at least 1,250 hours during the 12-month period immediately preceding the commencement of the requested leave.
- You are employed at a work site where 50 or more employees are employed by the Company within 75 miles of that work site ("eligible employees").

To the extent permitted by law, leave taken pursuant to FMLA will run concurrently with Workers' Compensation, Short Term Disability, and all other Company leave policies.

Procedure for Applying for FMLA Leave

If you desire and require an FMLA leave of absence under this policy, you **must** notify your supervisor and your office manager or Human Resources at least 30 calendar days in advance of the start of the leave when the need for such leave is reasonably foreseeable (as in the case of a birth, the placement for adoption for a son or daughter, or a planned medical treatment for a serious health condition). However, if the date of the birth, placement, or planned medical treatment requires leave to begin in less than 30 calendar days, you must provide such notice as soon as it is both possible and practical. **Failure to provide timely notice may result in a delay or denial of FMLA leave.**

Upon notification of the request for FMLA leave, the Company will send an FMLA rights information notice to you. You will be required to provide a health care provider's certification of the leave. The information must be submitted to the Company within 15 business days from the date of the FMLA rights information is sent to you.

If you are granted leave under the FMLA, you may be required to furnish periodic reports every 30 calendar days to Human Resources. Failure to provide the Company with requested information within the time frames may result in a delay in approving your leave or in the denial of your leave.

Reasons for Leave

The law allows eligible employees to take up to 12 workweeks of leave during any 12-month period for the following reasons:

- The employee's own serious health condition
- To care for a spouse, son, daughter, or parent with a serious health condition
- The birth of a child or the placement of a child with the employee for adoption or for foster care
- Any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a military member on covered active duty, called to covered active duty status, or notified of an impending call or order to covered active duty

Family Military Leave

The FMLA allows qualified employees with family members actively or formerly in the military to take leave under two circumstances:

- Qualifying exigency
- Military caregiver

State law provisions. In addition to these federal requirements, state laws may also provide leave rights and accommodations to military personnel and their families.

The U.S. Department of Labor (DOL) Wage and Hour Division is responsible for enforcing the FMLA

Email Benefits@down2earthinc.com for assistance.

COBRA Continuation

Federal law requires the Company to offer employees and their families the opportunity for a temporary extension of health coverage or "continuation coverage" at group rates in certain instances where coverage under the plan would otherwise end.

To Qualify for COBRA Coverage

Employees – as an employee of the Company covered by the medical, dental and/or vision plans, you have the right to elect the continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment for reasons other than gross misconduct on your part.

Spouses – As the spouse of an employee covered by the Company's health plan, you have the right to choose continuation coverage for yourself if you lose group health coverage for any of the following reasons:

- The death of our spouse who was an employee of the Company
- A termination of your spouse's employment for reasons other than gross misconduct
- A reduction in your spouse's hours of employment with the Company
- Divorce or legal separation from your spouse
- Your spouse becomes entitled to Medicare

Dependent Children – Dependent children of employees of the Company covered by the group health plan have the right to continuation of coverage if group health coverage is lost for any of the following reasons:

- The death of a parent who was an employee of the Company
- The termination of a parent's employment for reasons other than gross misconduct or reduction of a parent's hours of employment with the Company
- Parent's divorce or legal separation
- A parent who is an employee of the Company becomes entitled to Medicare
- The dependent ceases to be a dependent child under the terms of the health plan.

Patient Protection Disclosure

Aetna generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the medical network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the medical network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Aetna member information number listed on the back of your Aetna identification card.

HIPAA Notice

To: Employees (both active and inactive), retirees, dependents, and COBRA beneficiaries who are eligible to participate in any of the health plans offered by Seasons Service Select and its subsidiaries (the "Company")

Effective: November 1, 2020

From: Human Resources Department

Subject: HIPAA Notice of Privacy Practices

The privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) became effective April 14, 2003. These federal regulations require covered entities, such as health plans, to provide plan participants with a notice of privacy practices describing the health-related information that is collected how it is used, and the ways in which the regulations permit it to be disclosed. These privacy notices also provide information on a participant's right to access, review, and if necessary, to have this information amended.

This HIPAA Notice of Privacy Practices for the health plans sponsored by the Company details the uses and disclosure that the plan may make on your health information along with your rights and the plan's obligations with respect to that information.

Notice of Health Information Privacy Practices
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures of PHI. The main reasons for which the Company may use and may disclose your PHI are in order to administer the Company's health benefit programs effectively and to evaluate and process requests for coverage and claims for benefits. The following describe these and other uses and disclosures.

Protected health information, individually identifiable health information. The information that the HIPAA Privacy Rule seeks to protect is designated as "protected health information" (PHI). PHI is defined in the regulations as individually identifiable health information that is transmitted by electronic means, maintained in an electronic form, or transmitted or maintained in any other form. This means that PHI includes almost all individually identifiable health information. Individually identifiable health information is health information (including demographic information) created or received by a covered entity that identifies the individual or includes information from which the individual could be identified. The covered entities are providers, health plans, and healthcare clearinghouses. "Health information" is information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for provision of health care to an individual.

Group health plans. A group health plan is an ERISA employee benefit welfare plan to the extent that it provides medical care whether insured or self-insured.

Treatment. Treatment means the provision, coordination, or management of healthcare and related services by providers, including the coordination or management by a provider with a third party; consultation between providers relating to a patient; or referrals from one healthcare provider to another.

Payment. Payment includes the activities of a health plan to obtain premiums or to provide coverage and benefits under the health plan. It also encompasses actions taken by a provider or plan to obtain or provide reimbursement for the provision of health care.
Healthcare operations. Healthcare operations include the following activities of a covered entity that relate to a covered function:

- Quality assessment and improvement including activities such as outcomes evaluation and development of clinical guidelines; population-based activities for improving health or reducing healthcare costs, protocol development, case

management and care coordination, contacting of healthcare providers and patients with information about treatment alternatives.

- Reviewing healthcare personnel competence and qualifications.
- Reviewing practitioner and provider performance.
- Reviewing health plan performance.
- Conducting training programs.
- Underwriting, premium rating, and other activities for the creation, renewal, or replacement of a health insurance contract or health benefits (including stop-loss insurance and excess of loss insurance).
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.
- Business planning and development such as conducting cost-management and planning-related analyses (including formulary development and administration, development or improvement of methods of payment, or coverage policies).
- Business management and general administrative activities including:
    - Management activities for complying with the HIPAA Privacy Rule.
    - Customer service, including the preparation of data analyses for policyholders, plan sponsors, or other customers.
    - Resolution of internal grievances.
    - The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity.
    - Creating de-identified health information or a limited data set and fundraising for the benefit of the covered entity.

Authorization for multiple purposes. In most cases, authorizations for different purposes may be combined. For example, an authorization, other than an authorization for a use or disclosure of psychotherapy notes, may be combined with any other authorization. However, an authorization that conditions the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on its provision may not be combined with another authorization. An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for the same purpose. An authorization for the use or disclosure of protected health information for a research study may be combined with any other type of written permission for the same research study, including another authorization for the use or disclosure of PHI or a consent to participate in such research.

Disclosures for workers' compensation. The Privacy Rule does not apply to workers' compensation insurers, workers' compensation administrative agencies, or employers, as such. However, these entities need access to the health information of individuals who are injured on the job or who have a work-related illness to process or adjudicate claims, or to coordinate care under workers' compensation systems. This information is usually obtained from healthcare providers who treat these individuals and who may be covered by the Privacy Rule. Because of the legitimate need of insurers and other entities involved in the workers' compensation systems to have access to individuals' health information as authorized by state or other law, and due to the significant variability among such laws, the Privacy Rule permits disclosures of health information for workers' compensation purposes in a number of different ways.

Disclosure of findings: pre-employment physicals, drug tests, and fitness-for-duty exams. The U.S. Department of Health and Human Services has stated that the authorization exemption for information provided for public health purposes may cover disclosure by a provider to an employer of the findings of pre-employment physicals, drug tests, and fitness-for-duty exams. This exemption, however, applies in a very limited circumstance when all the following three conditions are met:

1. The covered healthcare provider must provide the healthcare service to the individual at the request of the individual's employer or as a member of the employer's workforce.
2. The healthcare service provided must relate to the medical surveillance of the workplace or an evaluation to determine whether the individual has a work-related illness or injury.
3. The employer must have a duty under the Occupational Safety and Health Administration (OSHA), the Mine Safety and Health Administration (MSHA), or the requirements of a similar state law, to keep records on or act on such information.

Disclosing PHI to the plan sponsor

The HIPAA Privacy Rule recognizes that while a group health plan and the plan sponsor are distinct legal entities, that for practical purposes there is no distinction. Plan sponsors frequently perform functions for the plan. The regulations, therefore, allow group health plans, insurers, and HMOs to share PHI with the sponsor but only for "plan administrative functions." A plan or insurer may not disclose PHI to the sponsor for any other purpose without specific authorization. In addition, unless the PHI is limited to "summary health information" and "enrollment information," the plan will have to be amended in specified ways before the sharing of

the PHI will be allowed. Plan administrative functions are administrative functions performed by the plan sponsor on behalf of the group health plan and exclude functions performed by the plan sponsor in connection with any other benefit or benefit plan that it sponsors (Reg. Sec. 164.504). The required plan amendments must:

1. Set out the permitted and required uses and disclosures of PHI by the plan sponsor,
2. Provide that the group health plan will disclose PHI to the plan sponsor only upon receipt of a certification by the plan sponsor that the plan documents have been amended to incorporate a number of restrictions and obligations relating to the use and disclosure of PHI by the plan sponsor that the plan sponsor agrees to, *and*
3. Provide for the adequate separation between the group health plan and the plan sponsor in specific ways.

Summary health information

Summary health information is information that may be individually identifiable health information and summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan and that has been de-identified except that the geographic information need only be aggregated to the level of a five-digit ZIP code (Reg. Sec. 164.504).

Group health plans that only receive, use, and disclose summary health information are exempt from many requirements. And plans that only disclose summary health information to the plan sponsor do not have to be amended to comply with the HIPAA Privacy Rule.

De-identifying

De-identified health information is PHI from which items that could be used to identify an individual have been removed (Reg. Sec. 164.514). Such information is not individually identifiable health information and is not PHI.

A covered entity may determine that information is de-identified in two ways. Under the first method, a qualified person with knowledge and experience of statistics and the scientific principles of de-identification would determine that the risk that the information can be used to identify the subject is very small.

Under the second method, specific identifiers are stripped from the information. The identifiers that have to be stripped to de-identify the information are:

- Names.
- All geographic subdivisions smaller than a state, including street address; city; county; precinct; ZIP code and equivalent geocodes, except for the initial three digits of a ZIP code if the geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people and the initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000.
- All dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age (these ages may be aggregated into a single category of age 90 or older).
- Telephone numbers.
- Fax numbers.
- E-mail addresses.
- Social Security numbers.
- Medical record numbers.
- Health plan beneficiary numbers.
- Account numbers.
- Certificate/license numbers.
- Vehicle identifiers and serial numbers, including license plate numbers.
- Device identifiers and serial numbers.
- Web Universal Resource Locators (URL).
- Internet Protocol (IP) address numbers.
- Biometric identifiers, including finger and voice prints.
- Full-face photographic images and any comparable images.
- Any other unique identifying number, characteristic, or code, except for certain codes or means of record identification that will be used by the covered entity to re-identify the information.

Minimum necessary standard

One of the fundamental principles of the HIPAA Privacy Rule is that when using or disclosing PHI or requesting PHI from another covered entity, a covered entity must make a reasonable effort to limit the PHI to the "minimum necessary" to accomplish the purpose of the use, disclosure, or request (Reg. Sec. 164.502).

Note: Flexibility in applying the "minimum necessary" standard is provided because covered entities are allowed to make their own assessment of what PHI is reasonably necessary for a particular purpose, given the characteristics of their business and workforce, and to implement policies and procedures accordingly. HHS has stated that an absolute standard is not required, and covered entities need not limit information uses or disclosures to those that are absolutely needed to serve the purpose. All covered entities must implement a minimum necessary policy that includes identifying who in its workforce needs access to PHI to carry out their duties, the category or categories of PHI that each person needs, and any conditions appropriate to such access (Reg. Sec. 164.514).

For routine and recurring disclosures, a covered entity must implement policies and procedures (which may be standard protocols) that limit the PHI disclosed to the amount reasonably necessary to achieve the purpose of the disclosure. For all other disclosure requests, a covered entity must develop criteria designed to limit the PHI disclosed to the information reasonably necessary to accomplish the purpose for which disclosure is sought and have its privacy officer review each request on an individual basis in accordance with such criteria.

Exceptions. This minimum necessary requirement does not apply to:

- Disclosures to or requests by providers for treatment
- Disclosures to the individual that is the subject of the information
- Disclosures made pursuant to an individual's authorization
- Disclosures to the Department of Health and Human Services for enforcement purposes
- Uses or disclosures required by law
- Uses or disclosures required for compliance with HIPAA Administrative Simplification Rules

Note: Without the policy on routine disclosures, each routine disclosure will have to be individually reviewed by the privacy officer. A covered entity may presume, if the circumstances are reasonable, that a requested disclosure is the minimum necessary for the stated purpose in the following circumstances:

- When making permitted disclosures to public officials, if the public official represents that the information requested is the minimum necessary for the stated purpose.
- The information is requested by another covered entity.
- The information is requested by a professional who is a member of its workforce or is a business associate of the covered entity for the purpose of providing professional services to the covered entity, if the professional represents that the information requested is the minimum necessary for the stated purpose(s).
- Documentation or representations that comply with the specified requirements of Reg. Sec. 164.512(i) have been provided by a person requesting the information for research purposes.

A covered entity must also limit any request it makes for PHI from another covered entity to that which is reasonably necessary to accomplish the purpose for which the request is made. A policy or procedure may be implemented for routine and recurring requests.

For all other requests, a covered entity must develop criteria designed to limit the request for PHI to the information reasonably necessary to accomplish the purpose for which the request is made and review requests for disclosure on an individual basis in accordance with such criteria.

For all uses, disclosures, or requests to which the minimum necessary requirement applies, a covered entity may not use, disclose, or request an entire medical record, except when the entire medical record is specifically justified as the amount that is reasonably necessary to accomplish the purpose of the use, disclosure, or request.

Individual rights

The HIPAA Privacy Rule not only protects the privacy of individual's PHI but also gives them rights concerning the protected information (Reg. Sec. 164.522). Individuals have the following rights:

- The right to inspect and obtain a copy of the PHI except for psychotherapy notes, information that is compiled in anticipation of a legal proceeding, and in certain other circumstances.
- There is a right to request a review of a denial in certain circumstances, such as a denial to a personal representative on the grounds that provision of access to the representative is reasonably likely to cause substantial harm to the individual. Entities must act on a request no later than 30 days of receipt. A reasonable cost-based fee may be charged for copies. Denials are subject to the required complaint procedure.
- The right to request an amendment of PHI which may be denied. A denial is subject to the complaint procedure.
- The right to an accounting of certain disclosures of PHI during the six years prior to the request.
- The right to request restrictions on certain limited disclosures which may or may not be granted.
- The right to receive information from providers and health plans by alternate means at alternate locations if the individual states that disclosure could endanger the individual.

Health Information Privacy Officer

You may exercise the rights described in this Notice by contacting the office identified below, which will provide you with additional information.

SSS Down to Earth Opco LLC
Health Information Privacy Officer
2701 Maitland Center Parkway, Suite 200
Maitland, FL 32751

Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health & Cancer Rights Act (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHRCA benefits, contact your plan administrator.

Wellness Program Notice

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under a wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the plan administrator and we will work with you to find a wellness program with the same reward that is right for you in light of your health status.

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer 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). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

DOWN TO EARTH
LANDSCAPE & IRRIGATION

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, 2021. Contact your State for more information on eligibility -

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://www.dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

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IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
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	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – 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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – 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)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.maine.gov/dhhs/ofi/applications-forms 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	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, 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

Contact Information

Plan	Provider	Phone Number	Website
Medical Plan	Aetna	1-800-238-6716	www.aetna.com *Select Member Support*
HSA	PayFlex	1-844-729-3539	www.payflex.com
Dental Plan	Unum Group	888-400-9304	www.alwaysassist.com
Vision Plan	Unum powered by EyeMed	855-652-8686	www.eyemedvisioncare.com/unum
Accident Insurance	Unum	1-800-635-5597	www.unum.com
Critical Illness Insurance	Unum	1-800-635-5597	www.unum.com
Hospital Indemnity	Unum	1-800-635-5597	www.unum.com
Voluntary Life & AD&D Insurance	Unum	1-800-421-0344	www.unum.com
Voluntary Disability Insurance *salaried employees only*	Reliance Standard	1-800-351-7500	www.rsli.com
Down to Earth 401(k) Plan	American Funds	1-800-204-3731	myretirement.americanfunds.com/
DTE I Care Fund	Helping Hands	706-754-6884	www.DTEbenefits.com

For general questions about your benefits contact:

Benefits@down2earthinc.com
(321) 263-2700

About the Guide
This benefit summary provides selected highlights of the Down to Earth employee benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the Company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between information provided through this summary and the actual terms of the policies, contracts and plan documents are governed by the terms of these policies, contracts and plan documents. Down to Earth reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The Plan Administrator has the authority to make these changes.

Access the Down to Earth Benefits Website

Complete benefit enrollment online from any computer or mobile device. Review and update your contact information, dependents and emergency contacts and learn about and choose your benefits.

Website: www.DTEbenefits.com - **then push "login to your benefits"**

Your ID: Use your Social Security Number without dashes

PIN: Last four of your social security number plus last two numbers of your birth year. You will be prompted to change your PIN

> ***Example:***
> Social Security Number: 949-12-**1234**
> Date of Birth: 08/12/19**89**
> PIN: **123489**

View each section and choose an option. Once you complete the enrollment:

- Review and Sign using your PIN
- Enrollment is complete when you see the ***CONGRATULATIONS!*** message

Use the same login to access the system to review your benefit elections, process life event enrollment changes, or update beneficiaries. You can also change your PIN (password) at any time using the *Change My Pin* option on the *You & Your Family* menu.

Access the DTE Mobile Wallet

Down to Earth provides employees a mobile wallet in English and Spanish so they can easily access plan information and contacts

Bookmark www.mymobilewallet.com/dte today and ***view information from your computer or cell phone!***