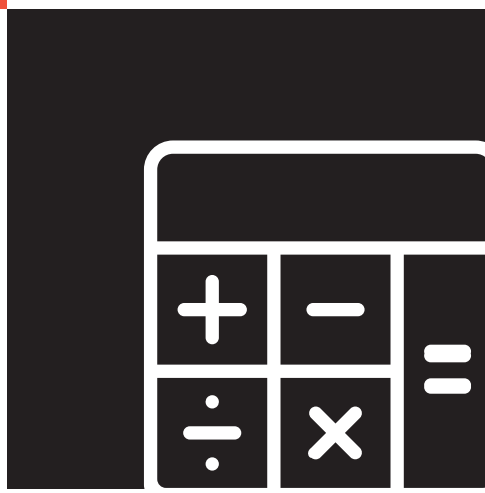
Ames Construction



October 1, 2024 – September 30, 2025

Benefits Guide

Enrolling in Your Benefits

Contact the Call Center to Enroll: 877-328-2607 (Available Mondays to Fridays, from 8 am to 5 pm, CST) or Enroll via your Workday Account.

Review the Confirmation Statement

Your Ames Construction Benefits

We understand the important role that benefits play in the lives of you and your family. As a new hire, and annually during open enrollment, you can elect a benefits package that gives you and your family the right coverage for your needs.

This benefits guide can help to familiarize you with Ames' benefit options. It also provides useful tips, tools and resources to help you think through your options and make wise decisions.

As you prepare to enroll, consider your benefit coverage needs for the upcoming year. For example, is your family financially protected if you can't work due to an accident or illness?

Getting the most value from your benefits depends on how well you understand your plans and how you choose to use them. Be sure to read this entire guide for important information about your benefit options.

Table of Contents

Benefit Basics

Your benefits are a partnership between you and Ames. The table below outlines how you and Ames share costs for benefits. The tax treatment shows whether your contribution is taken from your paycheck before or after taxes.

Benefit	Tax Treatment	Who Pays
Medical and Pharmacy	Pretax	Ames & You
Dental	Pretax	Ames & You
Vision	Pretax	Ames & You
Health Savings Account (HSA)	Pretax	Ames & You
Dependent Care Flexible Spending Account	Pretax	You
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	After-tax	Ames
Voluntary Life & AD&D Insurance	After-tax	You
Short-Term Disability	After-tax*	Ames
Long-Term Disability	After-tax*	Ames
Accident Insurance	After-tax	You
Critical Illness Insurance	After-tax	You
Hospital Indemnity Insurance	After-tax	You
401(k) Retirement Plan	Pretax & After-tax	Ames & You

*STD and LTD benefit payments are not taxable to the employee.

Eligibility

Who's eligible?

Employees

Full-time, non-union employees of Ames Construction are eligible for the benefits described in this guide. Benefits are effective on the first of the month following date of hire.

Dependents

You may enroll your eligible dependents in the same plans you choose for yourself. Eligible dependents on the Medical plan include:

- Your legal spouse, common law spouse or domestic partner (as defined by applicable state law that the employee resides in and the Ames SPD)
- Your children up to age 26.

Note: Unmarried children over the age of 26 may continue to be covered if they are incapable of self-support due to a disability. Proof of disability is required.

Following enrollment, a dependent audit is conducted to ensure only legal, qualified dependents are enrolled in health insurance. If required paperwork is not submitted to show dependents are eligible, they will be removed. Enrolling ineligible dependents will result in disciplinary action.

How and when to enroll?

If you wish to participate in benefits, you must enroll no later than two weeks prior to your eligibility date or during the annual Open Enrollment period. However, once you are benefits-eligible, you will be enrolled automatically in the Short-Term Disability, Long-Term Disability and Group Life and Accidental Death and Dismemberment (AD&D) plans provided by Ames at no cost to you.

Remember

- Ames' plan year runs from October 1, 2024 through September 30, 2025.
- The choices you make at this time will be effective through the end of the plan year unless you experience a qualified status change.
- Ames reserves the right to conduct an eligibility audit to ensure your dependents are eligible under the plan.

Making changes during the year

The choices you make upon your eligibility remain in effect through the end of the plan year. Once you are enrolled, you must wait until the next Open Enrollment period to change your benefits or add or remove coverage for dependents, unless you have a qualified status change as defined by the IRS.

Examples of a qualified status change include, but are not limited, to the following:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in your residence or workplace (if your benefit options change)
- Loss of other coverage
- Change in your dependent's eligibility status because of marriage, age, etc.
- Your spouse's Open Enrollment that occurs at a different time of the year

The IRS mandates that changes to your coverage due to a qualified status change must be reported to your HR representative within 30 days of that life event. Proof of the qualified status change is required (marriage certificate, divorce decree, birth certificate, loss of coverage letter, etc.).

Note: Any change you make to your coverage must be consistent with the change in status.

Medical and Pharmacy Plan Overview

We offer the choice of two medical plans through Blue Cross and Blue Shield of Minnesota. Both of the medical options include coverage for prescription drugs through CVS Caremark. To select the plan that best suits your family, consider the key differences between the plans, the cost of coverage (including payroll deductions) and how the plan covers services throughout the year.

Understanding how your plan works

1. Your deductible

- You pay out-of-pocket for most medical and pharmacy expenses, except those with a copay, until you reach the deductible.
- If you are enrolled in the HDHP w/ HSA Plan, you can pay for these expenses from your Health Savings Account (HSA).

2. Your coverage

- Once your deductible is met, you and the plan share the cost of covered medical and pharmacy expenses. The plan will pay a percentage of each eligible expense, and you will pay the rest.

3. Your out-of-pocket maximum

- When you reach your out-of-pocket maximum, the plan pays 100% of covered medical and pharmacy expenses for the rest of the plan year. Your deductible and coinsurance apply toward the out-of-pocket maximum.

Embedded deductibles and out-of-pocket maximums

With an embedded approach, each person only needs to meet the individual deductible and out-of-pocket maximum before the plan begins paying its share for that individual. (And, once two or more family members meet the family limits, the plan begins paying its share for all covered family members.) **Both the Traditional Copay Plan and the High Deductible Health Plan with Health Savings Account (HDHP w/ HSA Plan) have an embedded deductible.**

Making the most of your plan

Getting the most out of your plan also depends on how well you understand it. Keep these important tips in mind when you use your plan.

- **In-network providers and pharmacies:** You will always pay less if you see a provider within the medical and pharmacy network.
- **Preventive care:** In-network preventive care is covered at 100% (no cost to you). Preventive care is often received during an annual physical exam and includes immunizations, lab tests, screenings and other services intended to prevent illness or detect problems before you notice any symptoms.

Understanding your pharmacy coverage

- **Mail order pharmacy:** If you take a maintenance medication on an ongoing basis for a condition like high cholesterol or high blood pressure, you are required to use the Mail Order Pharmacy to save on a 90-day supply.
  - To manage your prescriptions, refills, mail orders and plan information, go to www.caremark.com to register your account.
- **Prescription categories:** Medications are categorized by cost, safety and effectiveness. These tiers also affect your coverage.
  - **Generic** – A drug that's equivalent to brand-name drugs in use, dose, strength, quality and performance, but is not trademarked.
  - **Brand preferred** – A drug with a patent and trademark name that is considered "preferred" because it's safe and effective and usually less expensive than other brand-name options.
  - **Brand non-preferred** – A drug with a patent and trademark name that is "not preferred" because it's usually more expensive than other generic and brand preferred options.
  - **Specialty** – A drug that requires special handling, administration or monitoring. Most can only be filled by a specialty pharmacy and have additional required approvals.
- **PrudentRx:** PrudentRx is available for Specialty drugs when enrolled in the Traditional Copay Plan.
  - PrudentRx is a prescription plan that allows employees to get select specialty medications at no cost.
  - If you are currently taking one or more medications included on the PrudentRx drug list, you will receive a welcome letter from PrudentRx providing information about the program and how it pertains to your medication.
  - If you choose to opt out of the program, you will be responsible for 30% coinsurance for specialty medications.

Medical and Pharmacy Coverage

Below is a summary of the Medical Plan. Please see the Summary of Benefits and Coverage for more detailed information.

Medical Plan Provisions	Traditional Copay Plan In-Network	HDHP w/ HSA Plan In-Network
Company Contribution to HSA (Individual/Family)	None	$1,500/$3,000
Annual Deductible (Individual/Family)	$500/$1,000	$3,200/$6,400
Out-of-Pocket Maximum (Includes Deductible, Copays and Coinsurance)	$2,000/$4,000	$4,000/$8,000
Preventive Care	Covered at 100%	Covered at 100%
Well Child Care (up to age 6)	Covered at 100%	Covered at 100%
Immunizations	Covered at 100%	Covered at 100%
Primary Care Provider Office Visit	$25 copay	20%*
Specialist Office Visit	$25 copay	20%*
Doctor on Demand	Covered at 100%	Covered at 100%
Diagnostic or Imaging	20%*	20%*
Chiropractic Office Visit	$25 copay	20%*
Inpatient Hospital Services	20%*	20%*
Outpatient Hospital Services	20%*	20%*
Urgent Care	$50 copay	20%*
Emergency Room	$150 copay	20%*
Retail Pharmacy (30-day Supply) / Mail Order (90-day supply)		
Generic	$10 copay	20%*
Brand Preferred	$20 copay	20%*
Brand Non-Preferred	$35 copay	20%*
Specialty	30% coinsurance ($0 out of pocket if enrolled with PrudentRx)	20%*

*Your coinsurance after the deductible is met

Finding In-Network Medical Providers

- To see if a doctor, clinic or hospital is in a specific network, log in to bluecrossmnonline.com and use the "Find a Doctor" tool or call customer service.
- When searching for providers, Utah members should search utilizing the National BlueCard network. Members outside of Utah should search utilizing the BlueCard PPO network.

Premium Bundled Plans

Medical, dental, and vision insurance coverages are bundled together. Ames pays the majority of the cost of these benefits. Your premium portion is paid on a monthly, pretax basis. Employees have a choice of two plan designs – a Traditional Copay Plan and an HDHP w/ HSA Plan.

Monthly Premium	Traditional Copay Plan		HDHP w/ HSA Plan	
	Employee Only	Family	Employee Only	Family
Base Pay < $104k	$60.00	$135.00	$30.00	$75.00
Base Pay ≥ $104k	$90.00	$165.00	$50.00	$100.00

Medical Plan Resources

Doctor on Demand

Whether you're at home, at work, traveling or you simply want a more convenient way to see a doctor, all you need is a smartphone, tablet or computer to get fast and convenient care. Video visits can be done in just minutes, with no travel time. It's quick, it's convenient and it saves you money.

With Doctor on Demand, board-certified doctors are available 24/7, 365 days a year to treat many common medical conditions. You can also schedule next-day appointments to see licensed psychologists and psychiatrists between 7 a.m. and 10 p.m., local time.

With just a phone call away, you can get the care you need for **physical and mental health issues**, such as:

- Cold and flu
- Sinus infections
- Nausea and vomiting
- Asthma
- Allergies and rashes
- Urinary tract infections
- Headaches and migraines
- Stress and anxiety
- Insomnia
- Depression and mood swings
- Trauma and loss

How much does a visit cost?

The cost is typically less than an in-person visit.

- Medical: $0 member cost
- Psychology: $0 member cost
- Psychiatry: $0 member cost

Note: Depending on your health plan, all or some of the costs may be covered. Pricing shown is for 2024 and is subject to change.

To learn more or to sign up, visit www.doctorondemand.com/bluecrossmn.

dr. on demand by Included Health

Savings and Spending Accounts

Ames offers several accounts that enable you to pay for eligible expenses tax-free. The IRS provides a list of eligible expenses for each type of account at www.irs.gov.

Health Savings Account (HSA)

Available to those enrolled in the HDHP w/ HSA Plan as long as you are not enrolled in any other health coverage or Medicare, or claimed as a dependent on someone else's tax return.

Dependent Care FSA

Use for eligible childcare expenses for dependents under age 13 or elder care.

You will receive an Optum Bank HSA card to use at point of sale. Dependent Care FSA reimbursement is done through your Optum portal account.

Comparison of accounts

	HSA	Dependent Care FSA
Does the company contribute? *Amount for plan year 2024-2025*	✓ Employee: $1,500 Employee +1 or Family: $3,000	X
Can I contribute my own savings?	✓	✓
Is there an IRS maximum annual contribution*?	✓ **For 2024:** Employee: $4,150 and Family: $8,300 **For 2025:** Employee: $4,300 and Family: $8,550 Those 55 and older can contribute an additional $1,000 annually.	✓ $5,000
Will my savings roll over each year?	✓ Unlimited	X
Will I earn interest on my savings?	✓	X
Are the savings tax-free? *In most states*	✓	✓
Do I keep the money if I leave the company?	✓	X
Can I also have a Dependent Care Flexible Spending Account (FSA)?	✓	N/A

Note: *Contributions made in excess of these annual limits may become taxable income to the employee. It is the employee's responsibility to stay within the IRS limits.

Health Savings Account

This year, as part of our effort to help you maximize your benefits, we want to help you understand how the High Deductible Health Plan with Health Savings Account (HSA) can help you save money. A Health Savings Account (HSA) is a savings account that belongs to you that is paired with the HDHP w/ HSA Plan. It allows you to make tax-free contributions that you can use to pay for current and future medical expenses for you and your dependents.

Our HSA is administered by Optum Bank. When you seek medical care under the HDHP, you pay for 100% of the services (up to the deductible amount) using funds from your HSA or out of your own pocket. (Remember that preventive care is paid at 100% by our medical plan). Once you meet the deductible, services are covered under the medical plan's benefit schedule and you can use your HSA funds to pay for coinsurance, copays and eligible expenses not covered by the plan.

START IT

- Contributions to an HSA are tax-free for you – whether they come from you or the company. Ames contributes $1,500 annually for individual coverage and $3,000 annually for family coverage. (**Note:** Company contributions are pro-rated on a per-period basis.)

BUILD IT

- All of the money in your HSA is yours (including any contributions deposited by the company) even if you leave your job, change plans or retire.
- You contribute to your Health Savings Account through pretax payroll deductions.
- The total of your contributions and the company's can be up to $4,150 for individual coverage and $8,300 for family in 2024 and up to $4,300 for individual coverage and $8,550 for family in 2025.
- If you are age 55 or older, you can contribute an additional $1,000 per year.

USE IT

- You can withdraw your money tax-free at any time, as long 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. (**Note:** Tax laws vary by state.)

Eligibility details

- You must be enrolled in Ames Construction's HDHP w/ HSA medical plan.
- You must not be enrolled in Medicare or TRICARE and must not be covered by any other health plan (i.e. a spouse/ domestic partner's plan) that is not an HSA-qualified plan.
- You must not be claimed as a dependent on someone else's tax return.

Dependent Care FSA

A Dependent Care Flexible Spending Account (FSA) helps you pay for dependent care costs using tax-free dollars. Each pay period, you decide how much money you would like to contribute. Your contribution is deducted from your paycheck on a pretax basis and is put into the Dependent Care FSA. When you incur expenses, you can access the funds in your account to pay for *eligible* expenses.

Eligible expenses	Annual contribution limits
Dependent care expenses including day care, after school programs for children under age 13 or elder care programs so you can work or attend school full-time.	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns).

Important information about your Dependent Care FSA

- Your FSA elections are effective from October 1, 2024 to September 30, 2025.
- Claims for reimbursement must be submitted by December 31, 2025.
- Please plan your contributions carefully. Any unused money remaining in your account(s) will be forfeited. This is known as the “use it or lose it” rule and it is governed by Internal Revenue Service regulations.
- FSA elections do not automatically continue from year to year; you must actively enroll each year.
- You can only change your FSA contribution amount if you experience a qualified status change.

Dental Plan

It's important to have regular dental exams and cleanings so problems are detected before they become painful – and expensive. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and is an important part of maintaining your overall health. We offer a dental plan through Delta Dental of Minnesota.

Below is a summary of the Delta Dental Plan. Please see your Member Benefit Document for more detailed information.

Plan Provisions	Delta Dental PPO	Delta Dental Premier	Non-Participating
Annual Deductible (Individual/Family)	$50/$150	$50/$150	$50/$150
Plan Year Maximum	$2,000 per individual	$2,000 per individual	$2,000 per individual
Diagnostic and Preventive Services (e.g., X-rays, cleanings, exams)	Covered at 100%	Covered at 100%	Covered at 100%
Basic Services (e.g., fillings)	20%*	20%*	20%*
Major Restorative (e.g., crowns and crown repair)	50%*	50%*	50%*
Endodontics (e.g., root canal therapy)	20%*	20%*	20%*
Periodontics (surgical or non-surgical)	20%*	20%*	20%*
Prosthetics (e.g., dentures, bridges)	50%*	50%*	50%*
Orthodontia (children from ages 8 to 18)	50%, up to a lifetime maximum of $5,000 per individual	50%, up to a lifetime maximum of $5,000 per individual	50%, up to a lifetime maximum of $5,000 per individual

*Your coinsurance after the deductible is met

Finding In-Network Dental Providers

- You may locate participating Dental providers by accessing the Delta Dental Minnesota website at www.deltadentalmn.org and selecting "Find a Dentist" in the upper-right corner of the screen. The interactive dentist search tool will walk you through how to find a participating dentist.
- You may also call customer service at 800-448-3815 for assistance in finding a dentist.

Get the most from your dental plan

- **In-Network Dentists** – Dentists who have signed a participating network agreement with Delta Dental have agreed to accept the maximum allowable fee as payment in full.
- **Non-Participating Dentists** – Non-Participating dentists have not signed an agreement and are not obligated to limit the amount they charge; the member is responsible for paying any difference to the Non-Participating dentists.
- **Free annual check-up** – Use free preventive care to keep your mouth and gums healthy all year long.
- **Use your FSA or HSA funds** – Help pay for eligible out-of-pocket dental expenses.

DELTA DENTAL®

Vision Plan

The vision plan provides coverage for routine eye exams and pays for all or a portion of the cost of glasses or contact lenses. You can choose any provider; however, you always save money if you see in-network providers. We offer a vision plan through VSP.

Below is a summary of the VSP Vision Plan. Please see your Member Benefit Document for more detailed information.

Plan Provisions	VSP Choice Plan	
	In-Network	Out-of-Network
Well Vision Exam	$10 copay	Up to $45
Frames	$300 allowance, then 20% off remaining balance	Up to $70
Lenses		
▪ Single Vision	Covered at 100%	Up to $30
▪ Lined Bifocal	Covered at 100%	Up to $50
▪ Lined Trifocal	Covered at 100%	Up to $65
▪ Lenticular	Covered at 100%	Up to $100
Contact Lenses		
▪ Elective	$300 allowance	Up to $105
▪ Medically Necessary	Covered at 100%	Up to $210
Frequency		
▪ Exam	Once every 12 months	Once every 12 months
▪ Lenses	Once every 12 months	Once every 12 months
▪ Frames	Once every 12 months	Once every 12 months
▪ Contact Lenses	Once every 12 months	Once every 12 months

Finding In-Network Vision Providers

- You may locate participating Vision providers by accessing the VSP website at www.vsp.com and selecting "Find a Doctor" in the upper-left corner of the screen, then enter your ZIP code.
- You may also call VSP's Member Services at 800-877-7195 for assistance in finding a provider.

vsp vision care

Life Insurance

Life insurance is an important part of your financial wellbeing, especially if others depend on you for support. Ames provides basic life and AD&D insurance for employees and offers voluntary insurance options for employees and their dependents through MetLife.

Basic life and AD&D insurance

- Ames provides basic life and AD&D coverage to all eligible employees at **no cost** equal to $50,000.
- In the event of your death, our life insurance policy will help provide a general safety net for your beneficiaries.
- If your death is the result of an accident or if an accident leaves you with certain debilitating injuries, you'll be covered under our Accidental Death and Dismemberment insurance for the same amount.
- The Basic Life and AD&D insurance is paid in full by Ames and is provided to you through MetLife.
- Coverage is automatic; you do not need to enroll.

Voluntary life and AD&D insurance

- You may choose to purchase additional life and AD&D coverage for yourself and your dependents at affordable group rates.
- The employee must elect coverage in order to purchase voluntary life and AD&D coverage for their spouse and dependent child(ren).
- Amounts above the Guaranteed issue require submission of a health questionnaire and approval from MetLife.

Voluntary life and AD&D insurance for you	Voluntary life and AD&D insurance for your dependents	
Employee	**Spouse**	**Child(ren)**
▪ Increments of $10,000 up to the lesser of 5x your base annual salary or $500,000. ▪ The Guarantee Issue amount for newly eligible employees is $100,000. Any amount over $100,000 will require Evidence of Insurability (EOI). ▪ Employees who are currently enrolled can increase their voluntary life and AD&D election during annual enrollment by one increment, not to exceed the Guarantee Issue amount, without Evidence of Insurability (EOI). ▪ All late entrants (members who previously waived coverage) will be required to submit Evidence of Insurability (EOI).	▪ Increments of $5,000 up to a maximum of $100,000, not to exceed 50% of employee's voluntary life and AD&D election. ▪ The Guarantee Issue amount for newly eligible spouses is $25,000. Any amount over $25,000 will require Evidence of Insurability (EOI). ▪ All late entrants (members who previously waived coverage) will be required to submit Evidence of Insurability (EOI).	▪ 15 days to 6 months: $1,000 ▪ 6 months up to age 26: Options of $1,000, $2,000, $4,000, $5,000 or $10,000 ▪ All late entrants (members who previously waived coverage) will be required to submit Evidence of Insurability (EOI).

Premium Rates

The individual premium rate will depend on the employee's age. View the Age/Rate table on the succeeding page to determine how much this benefit will cost. To determine the monthly premium for Voluntary Life and AD&D coverage, follow these simple steps:

- Determine the amount of insurance you want to purchase.
- Using the table, determine the rate based on your age.
- Use the following formula to calculate your monthly premium amount: **Coverage Amount/1,000 x Rate = Monthly Premium**.

Example

A 45-year-old elects to purchase $10,000 of Voluntary Life and AD&D insurance.

Calculation: $10,000/1,000 x $0.37 = $3.70

The employee's monthly premium is **$3.70** per month.

Life Insurance (continued)

Voluntary Life/AD&D Rates

Age	Rate per $1,000 of Coverage	
	Employee	Spouse
Less than 30	$0.14	$0.14
30 to 34	$0.15	$0.15
35 to 39	$0.18	$0.18
40 to 44	$0.25	$0.25
45 to 49	$0.37	$0.37
50 to 54	$0.58	$0.58
55 to 59	$0.88	$0.88
60 to 64	$1.35	$1.35
65 to 69	$2.19	$2.19
70 and Above	$4.07	$4.07
Child	$0.29	

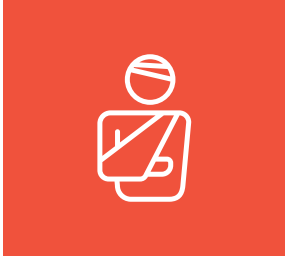
Disability Insurance

Disability insurance through MetLife provides income replacement should you become disabled and unable to work due to a non-work-related illness or injury. Ames provides eligible employees with disability coverage at **no cost** as shown below. Coverage is automatic; you do not need to enroll.

Short-Term Disability	Long-Term Disability
▪ Beginning the 1st of the month after your date of hire, you will be eligible for Short-Term Disability (STD) coverage. ▪ This benefit is paid by Ames and offered at no cost to you. ▪ The base wage continuation benefit is intended to replace a portion of the employee's income for those unable to work due to a non-work-related illness or injury that requires the regular care of a physician. ▪ There is a one-week waiting period before Ames provides wage continuation for up to 11 weeks at 50% of base wage up to $1,500 per week. ▪ The benefit payments are not taxable to the employee.	▪ Long-Term Disability (LTD) coverage enables you to receive part of your income while you are totally disabled and unable to work. ▪ This benefit is paid by Ames and offered at no cost to you. ▪ The elimination period is on the 90th day of disability. ▪ You are automatically enrolled for the company-paid coverage that replaces 50% of your base wages up to $10,000 per month. ▪ The benefit payments are not taxable to the employee.

How to File an STD Claim:

If you need to file a Short-Term Disability (STD) claim due to a disabling condition that prevents or limits your ability to work (employee's own medical leave), contact the MetLife Group Disability Reporting Line at 877-638-8262 or initiate a claim through the MyBenefits website at www.metlife.com/mybenefits.



Accident Insurance

Accident Insurance provides benefits to help cover the costs associated with unexpected bills due to covered accidents, regardless of any other insurance you have. If you purchase coverage and are hurt in a covered accident, you will receive a cash benefit for covered injuries that you may spend as you like.

With MetLife, you'll have a choice of two plans. Below are some examples of covered accidents and services.

Benefit Type	Low Plan	High Plan
Fractures	$100 to $8,000	$200 to $10,000
Dislocations	$100 to $8,000	$200 to $10,000
Burns	$75 to $10,000	$100 to $15,000
Concussion	$250	$500
Coma	$7,500	$12,000
Lacerations	$50 to $400	$75 to $700
Ground Ambulance	$300	$400
Emergency Care	$75 to $150	$100 to $200
Therapy Services	$35	$50
Pain Management	$75	$100
Lodging Benefit	$100 per day	$200 per day

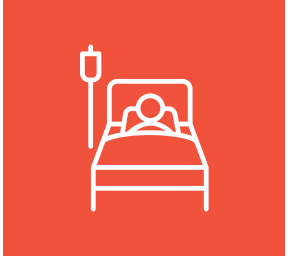
Accident Rates

Coverage Level	Low Plan	High Plan
Employee Only	$6.09	$8.88
Employee + Spouse	$12.18	$17.77
Employee + Child(ren)	$14.80	$21.64
Family	$17.43	$25.46

Health Screening Benefit: MetLife will provide an annual benefit of $50 per covered person per calendar year for taking one of the eligible screening/prevention measures.

Questions or want to enroll?

For more information and to enroll in Accident Insurance, call the Benefits Enrollment Center at 877-328-3607.



Critical Illness Insurance

Critical Illness Insurance provides cash to help pay for both medical expenses not covered by your medical plan as well as day-to-day expenses that may start to add up – like rent, mortgage, car payments, etc., while you are ill.

If you are diagnosed with a covered illness, you get a lump-sum cash benefit, even if you receive other insurance benefits.

Coverage Amounts

Employee	Spouse	Child(ren)
Options of $10,000, $20,000 or $30,000	100% of the Employee's Initial Benefit	50% of the Employee's Initial Benefit

Benefit Payment

Your plan through MetLife pays a lump-sum Initial Benefit upon the first verified diagnosis of a covered condition. Your plan also pays a lump-sum Recurrence Benefit for a subsequent verified diagnosis of certain covered conditions. A Recurrence Benefit is only available if an Initial Benefit has been paid for the same covered condition. Below are some examples of covered conditions.

Covered Conditions	Initial Benefit	Recurrence Benefit
Invasive Cancer	100% of Benefit Amount	100% of Initial Benefit
Non-Invasive Cancer	25% of Benefit Amount	100% of Initial Benefit
Coronary Artery Bypass Graft	100% of Benefit Amount	100% of Initial Benefit
Diabetes (Type 1)	100% of Benefit Amount	None
Loss of Sight, Hearing or Speech	100% of Benefit Amount	None
Heart Attack	100% of Benefit Amount	100% of Initial Benefit
COVID-19	25% of Benefit Amount	None
Kidney Failure	100% of Benefit Amount	None
Major Organ Transplant	100% of Benefit Amount	None
Alzheimer's Disease	100% of Benefit Amount	None
Multiple Sclerosis	100% of Benefit Amount	None
Stroke	100% of Benefit Amount	100% of Initial Benefit

Critical Illness Rates

	Rate per $1,000 of Coverage			
Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Less than 27	$0.38	$0.77	$0.56	$0.95
27 to 36	$0.51	$1.05	$0.69	$1.24
37 to 46	$0.93	$1.91	$1.11	$2.09
47 to 56	$1.82	$3.50	$2.00	$3.68
57 to 63	$3.12	$5.68	$3.30	$5.86
64 and Above	$4.87	$8.65	$5.05	$8.83

Note: Rates will increase when a covered person reaches a new age band. Rates are subject to change.

Health Screening Benefit: MetLife will provide an annual benefit of $50 per covered person per calendar year for taking one of the eligible screening/prevention measures.

Questions or want to enroll?

For more information and to enroll in Critical Illness Insurance, call the Benefits Enrollment Center at 877-328-3607.

Hospital Indemnity Insurance

Hospital Indemnity Insurance provides financial assistance to help cover hospital expenses.

With MetLife, you'll have a choice of two comprehensive plans which provide lump-sum cash payments for covered services regardless of any other payments you may receive from your medical plan. Below are some examples of covered services.

Covered Services	Benefit Limits	Low Plan	High Plan
Hospital Admission	1 time per sickness or injury	$500	$1,000
Intensive Care Unit (ICU) Admission	1 time per sickness or injury	$1,000	$2,000
Hospital Confinement	365 days per calendar year	$100	$200
ICU Supplemental Confinement	Pays an additional benefit for 30 days	$200	$400
Newborn Confinement	3 days per Confinement	$100	$100
Inpatient Rehabilitation	30 days per calendar year	$100	$100

Hospital Indemnity Rates

Coverage Level	Low Plan	High Plan
Employee Only	$7.62	$14.14
Employee + Spouse	$21.09	$38.33
Employee + Child(ren)	$12.83	$23.95
Family	$26.30	$48.14

Questions or want to enroll?

For more information and to enroll in Hospital Indemnity Insurance, call the Benefits Enrollment Center at 877-328-3607.

Mental Health Benefit

Lyra Health

Life is filled with change and uncertainty. The responsibilities and demands on our time can be overwhelming. It happens to all of us. Whenever you or your immediate family members need help dealing with life's challenges, our Mental Health benefit, administered by Lyra Health is here to help.

Lyra Health provides care for your emotional and mental wellbeing—how, when, and where you need it—at no cost to you. From self-guided care to access to top-notch therapists, Lyra offers something for everyone, no matter where you are in your mental health journey.

With research-backed treatment methods, quality providers, and digital resources, you and your dependents can tap into easy-to-use tools to support your mental wellness, including:

- 10 sessions of mental health coaching and therapy per year, with additional coaching and/or therapy sessions and medication management support available to those enrolled in the medical plan*
- Personalized plans for self-care developed alongside mental health experts who understand your needs
- On-demand resources for meditating, improving sleep, easing stress, and more

Get started with Lyra in three easy steps:

- **Step 1:** Visit www.amesconstruction.lyrahealth.com to create your account.
- **Step 2:** Take the care assessment to get matched with high-quality providers who have diverse backgrounds and identities. Lyra's providers are custom matched to you and have appointments available right away.
- **Step 3:** Meet with your provider virtually or in-person to get started on your journey.

Note: *Employees and their dependents enrolled in the medical plan are eligible for additional coaching and/or therapy sessions, beyond the 10 free sessions, and medication management support with a Lyra network provider. This care is subject to in-network outpatient deductibles, copays, and coinsurance as defined under your medical plan. If your medical benefits are through a union, you're eligible for the 10 free sessions.

Additional Benefits

Time Off

Ames provides time off from work for full time, non-union employees. This includes vacation, sick time and holidays.

Vacation

Years of Service	Monthly Accrual Rate (Non-Craft)	Weekly Accrual Rate (Craft/ Non-Union)	Annual Accrual Rate	Maximum Accrual Cap
Less than 5 Years	6.67 Hours	1.54 Hours	80 Hours	120 Hours
5 to 9 Years	10.00 Hours	2.31 Hours	120 Hours	180 Hours
10 Years or More	13.33 Hours	3.08 Hours	160 Hours	240 Hours

Sick Time

Accrual (Every 30 hours worked)	Annual Accrual Rate	Maximum Accrual Cap
1 Hour	48 Hours	80 Hours

Holidays

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving
- Day after Thanksgiving
- Christmas Eve
- Christmas

Military Leave

Eligibility

Employees are eligible for military leave in accordance with State and Federal law. Generally, employees reporting for active duty or training, whether on a voluntary or involuntary basis, in the Armed Forces, the Army National Guard, or the Air National Guard ("uniformed services") are eligible for military leave in accordance with Uniformed Services Employment and Reemployment Rights Act (USERRA).

Benefits Payable

For eligible employees who commence leave for active military duty or training, Ames will pay the difference for military duty if the employees' documented military pay (base pay) is less than the employee's base pay for up to one year while the employee is engaged in military training and/or on active duty.

If the employee's military pay is more than or equal to their base pay, the company will not provide any differential pay. Only base pay will be considered, other types of pay are excluded.

Military pay is exhausted after the maximum one year and the employee may choose to either use vacation time during military leave or elect to take an unpaid leave of absence.

Request for Military Leave

Employees should request a military leave of absence with Human Resources as soon as possible. Eligible employees will be granted a military leave of absence for up to five (5) years cumulatively. Leaves of absence in excess of five (5) years will be granted in accordance with applicable law.

Coordination with Other Policies

During the paid military leave period (up to one year), the employee's medical, dental and vision benefits will continue in effect on the same basis as an active employee. Life, accidental death and dismemberment, and disability insurance will not be continued or payable during military duty.

Employees who continue military duty after the paid military leave period (up to one year) will no longer be eligible. The employee will be responsible for paying premiums before leave commences, if applicable.

Return

Upon returning from service, members of the armed services and its reserve components will be reinstated to their previous job role, or similar a role, without loss of seniority or benefits and without any break in service for pension purposes in accordance with USERRA.

Additional Benefits (continued)

Parental Leave

The purpose of Paid Parental Leave is to enable the employee to care for and bond with a newborn. This policy will run concurrently with Family and Medical Leave Act (FMLA) leave, as applicable.

All regular, full-time employees of Ames Construction are eligible for Parental Leaves on the first day of the month after their date of hire if they meet one of the eligibility criteria listed below.

Type of Leave	Eligibility	Leave Duration	When to Take the Leave
Maternity Leave	Has given birth to a child	Six (6) weeks of paid leave per birth in a rolling 12-month period	Immediately following the birth and in one continuous period of leave
Paternity Leave	Partner has given birth to your child	One (1) week of paid leave per birth in a rolling 12-month period	Within six months following the birth and in one continuous period of leave
Adoption Leave (Primary Caregiver)	Has primary parental responsibility for the care of a child who has been added to the family through adoption	Six (6) weeks of paid leave per adoption in a rolling 12-month period	Immediately following the adoption and in one continuous period of leave
Adoption Leave (Secondary Caregiver)	Has parental responsibility for a child who has been added to the family through adoption, but is NOT the primary caregiver	One (1) week of paid leave per adoption in a rolling 12-month period	Within six months following the adoption and in one continuous period of leave

Note: Multiple births or adoption (e.g., the birth of twins or adoption of siblings) does not increase the total amount of paid parental leave granted.

Benefits Payable

- Paid benefits are 100% of the employee's regular base pay. Base pay does not include bonuses, commissions, overtime, per diem, other special pay or benefits.
- Parental leave payments will be made on the eligible employee's regularly scheduled payroll dates.

Coordination with Other Policies

- Employees under this policy are ineligible for short-term disability.
- Leave taken under this policy will run concurrently with leave under the FMLA. Please refer to the Family and Medical Leave Policy for further guidance on FMLA.
- Health benefits are continued during paid parental leave and the employee is responsible for any missed monthly insurance premiums.
- Employee does not accrue vacation time during parental leave.

Request for Paid Parental Leave

To request Paid Parental Leave, you must provide your Supervisor and Human Resources with the "Notice of the Request for Leave" form at least 90 days prior to the proposed date of the leave (or if the leave was not foreseeable, as soon as possible) and submit at least one of the approved documentation listed below:

Maternity Leave & Paternity Leave	Adoption Leave
▪ Birth certificate ▪ Hospital admission form associated with the delivery ▪ Documentation provided by the child's healthcare provider ▪ Document naming employee as a second parent (i.e., declaration of paternity or court order of filiation) ▪ Appropriate court documents	▪ Adoptive placement agreement ▪ Documentation provided by the adoption agency confirming the placement and date of placement ▪ Letter signed by the parent's/parents' attorney confirming the placement and date of placement ▪ Independent adoption placement agreement

Additional Benefits (continued)

Hinge Health

Hinge Health provides digital exercise therapy for muscle and joint pain. This program offers personalized care plans and coaching to help employees accomplish their health goals related to musculoskeletal (back, muscle joint) health.

Hinge Health gives you the tools you need to overcome nagging pain, recover from recent injuries, prepare for surgery, or find new strategies to stay healthy and pain free. Their programs are available to you and your eligible 18+ dependents at no cost. Plus, you can complete your customized care plan anytime, anywhere.

To learn more and apply, visit hinge.health/amesconstruction or call (855) 902-2777.

BenefitHub

BenefitHub is a comprehensive discount and reward platform that will help you save money. The platform has partnerships with thousands of vendors with savings on apparel, electronics, auto and home policies, pet insurance, national and local deals, hotels and travel and event tickets and more! You can browse deals, search by brand or category, or discover curated & personalized discounts relevant to your interests.

Visit amesperks.benefithub.com
Enter referral code: 7NMUCL

Retirement Benefits

401(k) Retirement Plan

Ames provides the opportunity to save for retirement through Empower. Employees may begin participating following the completion of 3 months of employment. After the waiting period, a pre-tax contribution of 3% of compensation will automatically be deducted from each paycheck if you do not opt out of participating. Employees may elect to save with traditional before tax dollars, after-tax Roth dollars, or a combination of both, up to IRS limits. If you are age 50 or older, you may contribute an additional catch-up contribution.

Ames will match 50% of the first 3% of your contribution. Eligible employees will be fully vested after four plan years, per the following schedule:

- Year 1: 25%
- Year 2: 50%
- Year 3: 75%
- Year 4: 100%

There is a wide arrangement of investment options that may be chosen, including Target Date Funds.

For more information, including changing your contribution, set up your Empower account online (empowermyretirement.com) or call customer service (844-465-4455).

To create your online account:

1. Navigate to empowermyretirement.com and select Register;
2. Choose I do not have a PIN tab;
3. Follow the prompts to create your username and password.

Profit Sharing Plan - Hourly Employees

After one year of employment, non-union, hourly employees who work 30 hours or more per week will be eligible for a $5.00 per hour worked contribution to a profit-sharing plan. Eligible employees will be fully vested after five years. Those on prevailing wage projects have no waiting period to participate and are immediately vested. This plan is administered through Empower.

Profit Sharing Plan - Salaried Employees

Non-union, salaried employees are eligible when they have worked a minimum of 1,000 hours during the fiscal year. This discretionary contribution is based on base pay plus bonus. Employees must be employed on December 31st to receive contributions. Eligible employees will be fully vested after five years. This plan is administered by Empower.

The five year vesting schedule for both profit sharing plans is as follows:

- Year 1: 20%
- Year 2: 40%
- Year 3: 60%
- Year 4: 80%
- Year 5: 100%

EMPOWER™ RETIREMENT

Helpful Benefit Terms

- **Brand preferred drugs** – A drug with a patent and trademark name that is considered "preferred" because it's safe and effective and usually less expensive than other brand-name options.
- **Brand non-preferred drugs** – A drug with a patent and trademark name that is "not preferred" because it's usually more expensive than other generic and brand preferred options.
- **Coinsurance** – The sharing of cost between you and the plan. For example, 80% coinsurance means the plan covers 80% of the cost of service after a deductible is met. You will be responsible for the remaining 20% of the cost.
- **Copay** – A fixed amount (for example $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of service.
- **Deductible** – The amount you have to pay for covered services each year before your health plan begins to pay.
- **Elimination period** – The time period between the beginning of an injury or illness and receiving benefit payments from the insurer.
- **Flexible Spending Accounts (FSA)** – FSAs allow you to pay for eligible health care and dependent care expenses using tax-free dollars. The money in the account is subject to the "use it or lose it" rule which means you must spend the money in the account before the end of the plan year.
- **Generic drugs** – A drug that's equivalent to brand-name drugs in use, dose, strength, quality and performance, but is not trademarked.
- **Health Savings Account (HSA)** – An HSA is a personal savings account for those enrolled in a High Deductible Health Plan (HDHP). You may use your HSA to pay for qualified medical expenses such as doctor's office visits, hospital care, prescription drugs, dental care and vision care. You can use the money in your HSA to pay for qualified medical expenses now, or in the future, for your expenses and those of your dependents, even if they are not covered by the HDHP.
- **High Deductible Health Plan (HDHP)** – A qualified High Deductible Health Plan (HDHP) is defined by the Internal Revenue Service (IRS) as a plan with a minimum annual deductible and a maximum out-of-pocket limit. These minimums and maximums are determined annually and are subject to change.
- **In-network** – A designated list of health care providers (doctors, dentists, etc.) with whom the insurance provider has negotiated special rates. Using in-network providers lowers the cost of services for you and the company.
- **Inpatient** – Services provided to an individual during an overnight hospital stay.
- **Mail order pharmacy** – Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.
- **Out-of-network** – Providers that are not in the plan's network and who have not negotiated discounted rates. The cost of services provided by out-of-network providers is much higher for you and the company. Higher deductibles and coinsurance will apply.
- **Out-of-pocket maximum** – The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year. Your annual deductible is included in your out-of-pocket maximum.
- **Outpatient** – Services provided to an individual at a hospital facility without an overnight hospital stay.
- **Plan year maximum** – The maximum benefit amount paid each year for each family member enrolled in the dental plan.
- **Primary Care Provider (PCP)** – A doctor (generally a family or internal medicine practitioner or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions.
- **Reasonable & Customary Charges (R&C)** – Prevailing market rates for services provided by health care professionals within a certain area for certain procedures. Reasonable and Customary rates may apply to out-of-network charges.
- **Specialist** – A provider who has specialized training in a particular branch of medicine (e.g., a surgeon, cardiologist or neurologist).
- **Specialty drugs** – A drug that requires special handling, administration or monitoring. Most can only be filled by a specialty pharmacy and have additional required approvals.

Benefit acronyms

ACA – Affordable Care Act

AD&D – Accidental Death & Dismemberment

HDHP – High Deductible Health Plan

FSA – Flexible Spending Account

HMO – Health Maintenance Organization

HSA – Health Savings Account

LTD – Long-Term Disability

PPO – Preferred Provider Organization

STD – Short-Term Disability

Contact Information

Coverage	Carrier	Phone	Website
Medical	Blue Cross and Blue Shield of Minnesota	Call the number on the back of your ID card Member Services: 866-873-5943	bluecrossmnonline.com
Prescription Drugs	CVS Caremark	877-264-2955	www.caremark.com
Virtual Visits	Doctor on Demand	N/A	www.doctorondemand.com/bluecrossmn
Health Savings Account (HSA)	Optum Bank	800-243-5543	www.optumbank.com
Dependent Care FSA	Optum Bank	800-243-5543	www.optumbank.com
Dental	Delta Dental of Minnesota	800-448-3815	www.deltadentalmn.org
Vision	Vision Service Plan (VSP)	800-877-7195	www.vsp.com
Life and AD&D Insurance	MetLife	866-492-6983	www.mybenefits.metlife.com
Disability Insurance	MetLife	800-300-4296	www.mybenefits.metlife.com
Accident Insurance	MetLife	800-438-6388	www.mybenefits.metlife.com
Critical Illness Insurance	MetLife	800-438-6388	www.mybenefits.metlife.com
Hospital Indemnity Insurance	MetLife	800-438-6388	www.mybenefits.metlife.com
Mental Health Benefit	Lyra Health	877-849-1353 Spanish speaking counselors are available.	www.amesconstruction.lyrahealth.com
Joint & Muscle Pain Program	Hinge Health	855-902-2777	www.hingehealth.com/for-individuals
Discounts & Perks	BenefitHub	N/A	amesperks.benefithub.com Enter Referral Code: 7NMUCL
401(k) Retirement Plan	Empower	844-465-4455	www.empowermyretirement.com
Profit Sharing Plan	Empower	844-465-4455	www.empowermyretirement.com
Benefits Enrollment Center		877-328-3607	

Legal Notices

Medicare Part D Creditable Coverage Notice

IMPORTANT NOTICE FROM AMES CONSTRUCTION, 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 Ames Construction, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this Notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this Notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this Notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later Notices might supersede this Notice.

- 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.
- Ames Construction, Inc. has determined that the prescription drug coverage offered by the Ames Construction, Inc. Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information, you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to wait to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period, you go **63 continuous days or longer without "creditable" prescription drug coverage (that is, prescription drug coverage** that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your Premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. However, there are some important exceptions to the late enrollment penalty.

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Legal Notices (continued)

Compare Coverage

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. See the Ames Construction, Inc. Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Ames Construction, Inc. Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Ames Construction, Inc. Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information, about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Ames Construction, Inc. prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

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

Contact Human Resources for further information, or call 952-435-7106. **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 Ames Construction, Inc. changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook.

You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare 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 whether or not you are required to pay a higher premium (a penalty).

Date:	October 1, 2024
Name of Entity/Sender:	Ames Construction
Contact—Position/Office:	Human Resources
Address:	2500 County Road 42 W Burnsville, MN 55337
Phone Number:	952-435-7106
Email:	corpbenefits@amesco.com

Nothing in this Notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

Legal Notices (continued)

Notice of Privacy Practices

Notice of Ames Construction, Inc. 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.

The effective date of this Notice of Ames Construction, Inc. Health Information Privacy Practices (the "Notice") is October 1, 2024.

Ames Construction, Inc.'s Health Plan (the "Plan") provides health benefits to eligible employees of Ames Construction, Inc. (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

For ease of reference, in the remainder of this Notice, the words "you," "your," and "yours" refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including employees, retirees, and COBRA qualified beneficiaries, if any, and their respective dependents.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

Your "Protected Health Information" (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. Protected health information includes information of a person living or deceased (for a period of fifty years after the death.)

The Plan is required by law to provide notice to you of the Plan's duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice according to the Plan's distribution process. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

The Plan is distributing this Notice, and will distribute any revisions, only to participating employees, retirees, and COBRA qualified beneficiaries, if any. If you have coverage under the Plan as a dependent of an employee, retiree or COBRA qualified beneficiary, you can get a copy of the Notice by requesting it from the contact named at the end of this Notice.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor's or other health care provider's privacy practices with respect to your PHI that they maintain.

Legal Notices (continued)

Receipt of Your PHI by the Company and Business Associates

The Plan may disclose your PHI to, and allow use and disclosure of your PHI by, the Company and Business Associates, and any of their subcontractors without obtaining your authorization.

Plan Sponsor: The Company is the Plan Sponsor and Plan Administrator. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the Company a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice.

The Plan may disclose your PHI to the Company for plan administration functions performed by the Company on behalf of the Plan, if the Company certifies to the Plan that it will protect your PHI against inappropriate use and disclosure.

Example: The Company reviews and decides appeals of claim denials under the Plan. The Claims Administrator provides PHI regarding an appealed claim to the Company for that review, and the Company uses PHI to make the decision on appeal.

Business Associates: The Plan and the Company hire third parties, such as a third party administrator (the "Claims Administrator"), to help the Plan provide health benefits. These third parties are known as the Plan's "Business Associates." The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or the Company to assist or carry out the terms of the Plan. In addition, these Business Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and the Company must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure, and will require their subcontractors and agents to do so, too.

For purposes of this Notice, all actions of the Company and the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered maintained by the Plan. So, when this Notice refers to the Plan taking various actions with respect to health information, those actions may be taken by the Company or a Business Associate on behalf of the Plan.

How the Plan May Use or Disclose Your PHI

The Plan may use and disclose your PHI for the following purposes without obtaining your authorization. And, with only limited exceptions, we will send all mail to you, the employee. This includes mail relating to your spouse and other family members who are covered under the Plan. If a person covered under the Plan has requested Restrictions or Confidential Communications, and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

Your Health Care Treatment: The Plan may disclose your PHI for treatment (as defined in applicable federal rules) activities of a health care provider.

Example: If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.

Example: The Plan might disclose information about your prior prescriptions to a pharmacist for the pharmacist's reference in determining whether a new prescription may be harmful to you.

Making or Obtaining Payment for Health Care or Coverage: The Plan may use or disclose your PHI for payment (as defined in applicable federal rules) activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.

Example: The Plan will receive bills from physicians for medical care provided to you that will contain your PHI. The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying, benefits with respect to such a bill.

Example: The Plan may consider and discuss your medical history with a health care provider to determine whether a particular treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

Legal Notices (continued)

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others.

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation and determination of cost sharing amounts)
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

The Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by the Company), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

Health Care Operations: The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities.

Example: If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a disease management program.

Example: If claims you submit to the Plan indicate that the stop-loss coverage that the Company has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes.

- Quality assessment and improvement activities
- Disease management, case management and care coordination
- Activities designed to improve health or reduce health care costs
- Contacting health care providers and patients with information about treatment alternatives
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs

The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.

- The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others
- Underwriting (with the exception of PHI that is genetic information) premium rating and performing related functions to create, renew or replace insurance related to the Plan
- Planning and development, such as cost-management analyses
- Conducting or arranging for medical review, legal services, and auditing functions
- Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

Legal Notices (continued)

The Plan also may use or disclose your PHI for purposes of assisting other health plans for which the Company is the plan sponsor, and any insurers and/or HMOs with respect to those plans, with their health care operations activities similar to both categories listed above.

Limited Data Set: The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.

Legally Required: The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.

Health or Safety: When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others. The Plan can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence

Law Enforcement: The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.

Lawsuits and Disputes: In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.

Workers' Compensation: The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs.

Emergency Situation: The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

Personal Representatives: The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: 1) you have been or may be a victim of domestic abuse by your personal representative; or 2) recognizing such person as your personal representative may result in harm to you; or 3) it is not in your best interest to treat such person as your personal representative.

Public Health: To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

Health Oversight Activities: The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.

Legal Notices (continued)

Coroner, Medical Examiner, or Funeral Director: The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties. Organ Donation. The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

Specified Government Functions: In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

Research: The Plan may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approves the research.

Disclosures to You: When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than Treatment, Payment, or Health Care Operations (and if you did not authorize the disclosure).

Authorization to Use or Disclose Your PHI

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact listed at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.

Furthermore, we will not: (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations); (2) sell your confidential information (unless under strict legal restrictions) (to sell means to receive direct or indirect remuneration); (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization; or (4) use or disclose psychotherapy notes unless required by law.

Additionally, if a state or other law requires disclosure of immunization records to a school, written authorization is no longer required. However, a covered entity still must obtain and document an agreement which may be oral and over the phone. The Plan May Contact You The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail.

> You should note that the Plan may contact you about treatment alternatives or other health related benefits and services that may be of interest to you.

Legal Notices (continued)

Your Rights With Respect to Your PHI

Confidential Communication by Alternative Means: If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact listed at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

Request Restriction on Certain Uses and Disclosures: You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact listed at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

Right to Be Notified of a Breach: You have the right to be notified in the event that the plan (or a Business Associate) discovers a breach of unsecured protected health information.

Electronic Health Records: You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Paper Copy of This Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact listed at the end of this Notice.

Right to Access Your PHI: You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact listed at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request. However, if you, or a third party requests a copy of your PHI, the fee limitations set out in the rules will apply only to your individual request for access to your own records but these fee limitations will not apply to an individual's request to transmit records to a third party.

Legal Notices (continued)

Right to Amend: You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact listed at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

Accounting: You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred more than six years before the date of your request, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact listed at the end of this Notice. Your request must state a time period which may not include dates more than six years before the date of your request. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Personal Representatives: You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

Complaints

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact listed at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Information

The Plan has designated the Human Resources Department as its point of contact for all issues regarding the Plan's privacy practices and your privacy rights. You can reach Human Resources at:

2500 County Road 42 W
Burnsville, MN 55337
Phone Number: 952-435-7106
corpbenefits@amesco.com

Legal Notices (continued)

Notice of Special Enrollment Rights Ames Construction, Inc. Employee Health Care Plan

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

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

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within 60 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **60 days** after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Human Resources
2500 County Road 42 W
Burnsville, MN 55337
Phone Number: 952-435-7106
corpbenefits@amesco.com

This Notice is relevant for healthcare coverages subject to the HIPAA portability rules.

Legal Notices (continued)

General Cobra Notice

General Notice of COBRA Continuation Coverage Rights (Continuation Coverage Rights Under COBRA)

Introduction

You're getting this Notice because you recently gained coverage under a group 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 your 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 (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they 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."

Legal Notices (continued)

When is COBRA continuation 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 in writing to the Plan Administrator. Any Notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

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 COBRA 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. If you believe you are eligible for this extension, contact the Plan Administrator.
- 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.

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 than COBRA continuation coverage. You can learn more about many of 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.

Legal Notices (continued)

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 https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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

For additional information regarding your COBRA continuation coverage rights, please contact:

Human Resources Department
2500 County Road 42 W
Burnsville, MN 55337
Phone Number: 952-435-7106
corpbenefits@amesco.com

Legal Notices (continued)

Women's Health and Cancer Rights Notice

Ames Construction, Inc. Employee Health Care Plan is required by law to provide you with the following Notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The Ames Construction, Inc. Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, 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 WHCRA benefits, please refer to your or contact your Plan Administrator at:

Human Resources Department
2500 County Road 42 W
Burnsville, MN 55337
Phone Number: 952-435-7106
corpbenefits@amesco.com

Legal Notices (continued)

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 January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: 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+)	**FLORIDA – Medicaid**
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

Legal Notices (continued)

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

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

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: https://www.mymaineconnection.gov/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: 1-800-977-6740
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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 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: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

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. 5218

Legal Notices (continued)

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	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 Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

Legal Notices (continued)

To see if any other states have added a premium assistance program since January 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Ames Construction

About this Guide

This benefit summary provides selected highlights of the Ames Construction, Inc. 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 any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. Ames Construction, Inc. reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.