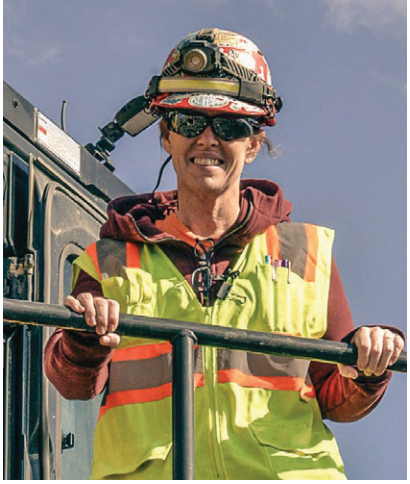





AMES**BENEFITS**

2026-27
Open Enrollment Guide

Benefits Open Enrollment:
August 17-September 4, 2026

Ames Construction




Table of Contents

Important Dates

August 17
Open Enrollment Begins
Access your enrollment via your Workday homepage

September 4
Open Enrollment Ends
Enrollment in Workday closes at 11:59 p.m. Central

October 1
New Benefits Start
Benefits are in effect until September 30, 2027

October 2 (Hourly) **or October 15** (Salaried)
1st Payroll with New Deductions
Review your paystub carefully to ensure your new deductions match your enrollment confirmation

January 1
Higher HSA Limits Begin
You may complete an HSA Change Form (available on the **Benefits Resource Site**) to increase your contribution

What's New This Year?

At Ames, people matter. We're Fueled by Family, which means looking out for one another, on the job and at home. That's why we invest in a comprehensive benefits program that supports our coworkers and their families.

While healthcare costs continue to rise nationwide, Ames has worked to minimize the impact on coworkers by keeping premium increases low and making limited changes to plan benefits over the years. Today, Ames invests approximately $25,836 per covered employee in healthcare coverage. The total investment across all covered employees and their family members is more than $19 million.

This year, we're introducing a few targeted changes designed to help manage rising healthcare costs while continuing to provide competitive benefits for coworkers in the years ahead. This guide highlights what's changing, what's staying the same, and what you need to know during Open Enrollment.

Ames Sets The Standard

At Ames, we rely on trusted industry experts to help us evaluate benefits and insurance trends, employee needs, and market insights so that we can make informed decisions about our benefits program. In doing so, here's what we found:

- Ames' benefits (especially medical) are more generous and have lower employee cost sharing than more than 90% of companies in general, and more than 95% of construction companies.
- Ames contributes three times more than the average company to your Health Savings Account if you choose the Health Savings medical plan.
- The Traditional Plan deductible is 25% lower than the norm in the construction industry.
- Ames coworkers who make under $100,000 pay about 80% less than the benchmark employee premium in the construction industry.

What's New This Year?

1. Plan Design Changes

To help sustain our benefits program for the long-term, we have made several updates to the Traditional Plan and the Health Savings Plan. For complete plan details, please refer to page 9. While deductibles, out-of-pocket maximums, and some copays have increased, several important benefits remain unchanged or have been enhanced.

Traditional Plan:

- Coinsurance (the percentage you pay after you have met the deductible) is staying the same
- Copays for primary care and urgent care are not changing
- If you are admitted to the hospital, you do not have to pay the $300 emergency room copay

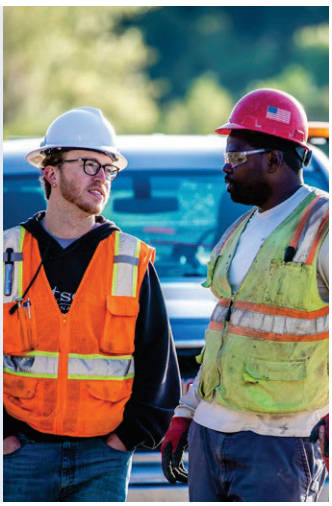
Health Savings Plan:

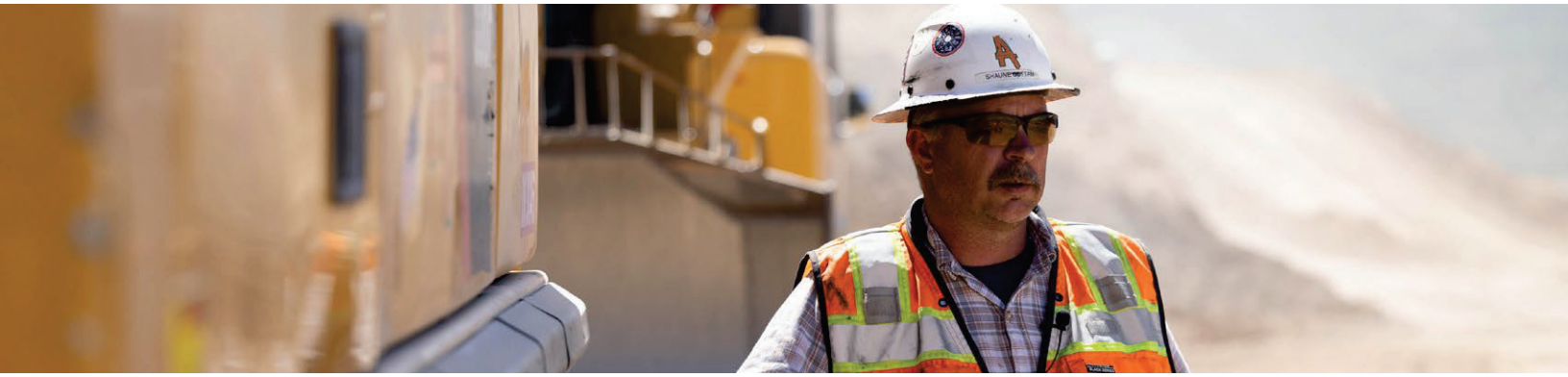
- Coinsurance (the percentage you pay after you have met the deductible) is staying the same
- After meeting the deductible, you will now pay a copay for prescription drugs — just like Traditional Plan members
- Health Savings Plan seed money is staying the same — $1,500 for employee-only coverage and $3,000 if you cover any dependents, on an annual basis

Understanding Our Self-Funded Health Plan

Ames offers a **self-funded health plan**, which means the company pays for all healthcare claims for employees and their covered family members directly. While Blue Cross Blue Shield administers the plan and processes claims, Ames finances the actual cost of care, rather than paying fixed premiums to an insurance carrier.

Because Ames pays the cost of healthcare claims directly, every healthcare decision affects the overall cost of our health plan. As healthcare costs increase, it can limit the resources available to invest in our business, our coworkers, and future opportunities. By making informed healthcare decisions, we can help manage costs and support the long-term success of Ames.





What's New This Year?

2. More Flexible Coverage Choices

New **You can choose medical/prescription, dental, and vision separately**

Historically, Ames has offered medical/prescription, dental, and vision coverage together as a bundled package. While this made enrollment simple, it also meant that coworkers paid for all three benefits, even if they didn't need them.

Starting this plan year (October 1, 2026 – September 30, 2027) you will have the flexibility to enroll in medical/prescription, dental, and vision coverage separately. This allows you to customize your Ames benefits in ways that weren't available before:

- You can enroll your spouse in just dental and vision if they have medical coverage elsewhere
- You can enroll young children in medical coverage only if they don't yet need dental or vision coverage
- You can opt out of vision coverage if you don't need it (vision exams are also covered under both medical plans)

Because you can choose each benefit separately, you can select the coverage that fits your family's needs and budget — ensuring you only pay for the benefits you want and need. **Note that medical and prescription coverage will remain bundled.**

Let's Get Personal

Ames will spend more than $25,000 per covered employee on healthcare expenses in 2026 — or more than $19 million for all covered employees and their family members.

Interested in how much Ames will specifically spend on your coverage? See page 26 to see how much Ames will pay for medical/prescription, dental, and vision coverage based on the option you choose and which family members you cover.

3. More Medical Coverage Tiers

New **You can choose the medical coverage that best reflects your family**

Until now, Ames has offered employee-only and family coverage. Starting this plan year, you can choose from four coverage tiers for medical and prescription coverage to match your family's needs.

- Employee only
- **New:** Employee + spouse (no coverage for children)
- **New:** Employee + children (no coverage for a spouse)
- Family (both spouse and children are covered)

These additional coverage options for medical and prescription coverage provide greater flexibility and may help reduce your benefit costs by allowing you to cover only the family members who need coverage.

How to Enroll

Open Enrollment: August 17 - September 4

Ames benefits are available to non-union coworkers who work 30 hours or more per week. New hires can enroll in Ames health benefits as soon as they are hired, and benefit choices go into effect on the first day of the month after the hire date.

During Open Enrollment, you will choose your benefits electronically in Workday. Your current elections will not roll over. After logging into Workday, you will see a task on the main page under **Awaiting Your Action**. Click on the task and select the **Let's Get Started** button to review benefit options.

When you enroll, you can:

- **Choose the benefits** you want to have during the new plan year (October 1, 2026 – September 30, 2027)
- **Add or drop dependents** you want to cover with your Ames benefits
- **Choose to contribute to a Health Savings Account** (if you choose the Health Savings medical plan)
- **Verify that your beneficiaries** for life and AD&D insurance are correct (recommended annually)

After submitting your enrollment, you'll have the option to print or save your confirmation statement. You'll also be able to refer back to your elections in Workday at any time by navigating to **Personal** > **Benefits & Pay Hub** and choosing the **Benefit Elections** option from the Benefits dropdown. Please note that the Benefit Elections page will show your benefits currently in place. If you've made any changes during Open Enrollment, you'll want to choose the Benefits by Date option and enter 10/1/2026 to confirm the changes.

Covering your dependents

Most benefits allow you to cover yourself as well as your dependents. Your eligible dependents are:

- Your legal spouse or common law spouse (as defined by the state in which you live and the Ames Summary Plan Description)
- Your children up to age 26 (age 25 for Accident Insurance, Hospital Indemnity Insurance, and Critical Illness)
- Unmarried children over the age of 26 if they are incapable of self-support due to a disability (proof of disability is required)

Making changes during the year

The choices you make during Open Enrollment are intended to stay in effect for the entire plan year (October 1, 2026 – September 30, 2027). However, certain life events may make it necessary to update your benefits during the year. If you have one of those life events (called a "qualified status change" by the IRS), then you may be eligible to make changes to your benefit elections mid-year instead of waiting until the next Open Enrollment period.

These types of changes include:

- Marriage or divorce
- Death of a covered dependent
- Birth or adoption of a child
- Loss of other coverage (for example, if you had coverage through your spouse, but it is no longer available)
- Your dependent child is no longer eligible for coverage because of age, marriage, etc.
- You choose or drop coverage through your spouse's job, and their Open Enrollment happens at a different time of the year

If you have a qualified status change, you must notify Human Resources and make changes to your benefits within 30 days of the change (e.g., within 30 days of the date you are married or birth date of your child).

How to Enroll

Choosing Your Benefits

There are three types of benefits provided by Ames:

- **Core benefits:** These benefits are paid by Ames and you are automatically enrolled. See page 23 for information on these benefits, which are not affected by Open Enrollment.
- **Shared-cost benefits:** You and Ames share the cost of these benefits.
- **Voluntary benefits:** Ames offers these benefits to you at discounted group rates, but you pay the full cost.

When you pay all or a portion of the cost, premiums are deducted from your paycheck on either a before-tax or after-tax basis.

- **Before-tax premiums** reduce the amount of your pay that is taxed, which may lower the amount of taxes that are withheld from your paycheck.
- **After-tax premiums** are subtracted from your paycheck after the taxes have been calculated, so benefits from the Plan are generally tax-free to you.

Benefit	Cost Sharing	Tax Treatment
You choose during Open Enrollment		
Medical and Prescription	Shared: Ames & You	Before-tax
Dental	Shared: Ames & You	Before-tax
Vision	Shared: Ames & You	Before-tax
Health Savings Account (HSA)	Shared: Ames & You	Before-tax
Voluntary Life and AD&D* Insurance	Voluntary: You	After-tax
Accident Insurance	Voluntary: You	After-tax
Critical Illness Insurance	Voluntary: You	After-tax
Hospital Indemnity Insurance	Voluntary: You	After-tax
Not Affected by Open Enrollment		
Short-Term Disability	Core: Ames	N/A
Long-Term Disability	Core: Ames	N/A
Basic Life and AD&D* Insurance	Core: Ames	N/A
Mental Health Benefits	Core: Ames	N/A
Virtual Physical Therapy	Core: Ames	N/A
401(k) Retirement Plan	Shared: Ames & You	Before-tax and After-tax options
Profit Sharing Plan	Core: Ames	N/A
ESOP Plan	Core: Ames	N/A
Paid Time Off, Holidays & Paid Leaves	Core: Ames	N/A
BenefitHub Perks	Core: Ames	N/A

**Accidental Death & Dismemberment*

MEDICAL:

Compare the Plans

Provider: Blue Cross Blue Shield

Ames offers two medical plan options. Both plans are offered through our partnership with Blue Cross Blue Shield of Minnesota and include additional programs for members to help protect their health.

	Health Savings Plan (HDHP Plan)	Traditional Plan (PPO Plan)
Monthly premium	Lower than Traditional Plan	Higher than Health Savings Plan
	See page 26 for specific premium information.	
Deductible	Individual: $3,500 Family: $7,000	Individual: $1,000 Family: $2,000
Limit on how much you pay in a year	Individual: $5,000 Family: $10,000	Individual: $3,000 Family: $6,000
How the deductible and out-of-pocket maximums work	Each person has their own individual deductible and out-of-pocket maximum. Once an individual meets their individual deductible, the Plan will start to pay 80% of that person's expenses. And once an individual meets the out-of-pocket maximum, then the Plan will pay 100% for the rest of the year. If two or more family members have expenses that combine to meet the family deductible or family out-of-pocket maximum, then the whole family can move on to the next level of benefits (either the Plan covering 80% or 100% of expenses).	Each person has their own individual deductible and out-of-pocket maximum. Once an individual meets their individual deductible, the Plan will start to pay 80% of that person's expenses. And once an individual meets the out-of-pocket maximum, then the Plan will pay 100% for the rest of the year. If two or more family members have expenses that combine to meet the family deductible or family out-of-pocket maximum, then the whole family can move on to the next level of benefits (either the Plan covering 80% or 100% of expenses).
Eligible to receive HSA seed money from Ames	Yes. If you cover yourself only: $1,500 If you cover dependents: $3,000 Contributions are paid monthly	No
Can I also make tax-free contributions to a health savings account?	Yes. Your contributions lower your taxes now and are available for you to use at any time in the future. To learn more, see page 12.	No
Preventive Care	No cost to you	No cost to you
Virtual Care through Doctor on Demand	No cost to you. Includes: Urgent care Care from psychologist and psychiatrist	No cost to you. Includes: Urgent care Care from psychologist and psychiatrist
Choose your own doctor	Yes	Yes
Go to a specialist without a referral	Yes	Yes
Copays for routine care	No — you pay a percent of the cost after meeting the deductible	Yes — whether or not you have met the deductible
Copays for prescription drugs	Yes — after meeting the deductible	Yes — whether or not you have met the deductible

MEDICAL:

Plan Details

Provider: Blue Cross Blue Shield

	Health Savings Plan (HDHP Plan)	Traditional Plan (PPO Plan)
Health Savings Account Seed Money	If you cover yourself: $1,500 If you cover dependents: $3,000	None
	When you use an in-network provider, you pay…	*When you use an in-network provider, you pay…*
Deductible	Individual: $3,500 Family: $7,000	Individual: $1,000 Family: $2,000
Out-of-pocket maximum	Individual: $5,000 Family: $10,000	Individual: $3,000 Family: $6,000
Preventive care (well-baby and child visits, annual physicals, routine immunizations and testing)	No cost to you	No cost to you
Office visit • Primary care • Specialist	20%* 20%*	$25 copay $40 copay
Virtual care through Doctor on Demand • When sick/urgent care • Emotional/mental care	No cost to you	No cost to you
Vision exam	No cost to you	No cost to you
Chiropractic care	20%*	$25 copay
Urgent care facility	20%*	$50 copay
Emergency room	20%*	$300 copay *(not charged if you are admitted)*
Lab work/X-ray (in doctor's office)	20%*	20%*
Lab work/X-ray (outside doctor's office)	20%*	20%*
Complex imaging (MRI, CAT scan, etc.)	20%*	20%*
Outpatient hospital	20%*	20%*
Inpatient hospital	20%*	20%*

**After meeting the deductible*

Finding In-Network Medical Providers

On the web: **bluecrossmnonline.com** and use the "Find a Doctor" tool

- **Coworkers in Minnesota** use the Aware Network
- **Coworkers in Utah/Nevada** use the National BlueCard/Regence/PAR Network
- **All other coworkers** use the BlueCard PPO Network

On the phone: Call 866-873-5943 or the number on the back of your ID card.

MEDICAL:

Prescription Drug Coverage

Provider: CVS Caremark

Both medical plan options include comprehensive prescription drug benefits. You can fill prescriptions at a local retail pharmacy or use the mail-order pharmacy for prescriptions you take regularly.

In-Network Retail Pharmacy *(up to 30-day supply)*	**Health Savings Plan (HDHP Plan)**	**Traditional Plan (PPO Plan)**
Generic formulary	$10*	$10
Preferred brand	$35*	$35
Other brand	$60*	$60
Specialty	30%*	30%

In-Network Mail Order or Select Retail Pharmacies *(up to 90-day supply)*	**Health Savings Plan (HDHP Plan)**	**Traditional Plan (PPO Plan)**
Generic formulary	$30*	$30
Preferred brand	$105*	$105
Other brand	$180*	$180
Preferred Specialty	30%*	30%**

**After meeting the medical plan deductible*
*** Could be available at no cost to you through PrudentRx. See below for more information.*

Do you take a medication regularly?

If you take a maintenance medication — for example, medication for diabetes, asthma, high blood pressure, or high cholesterol — you will be required to fill it in 90-day quantities through the CVS Maintenance Choice program. Your prescription can be picked up at your local CVS, select local pharmacies, or you can have it delivered to you by mail. If you would like to fill your prescriptions in 30-day quantities, you must call the phone number on the back of your member ID card to opt out of Maintenance Choice. Opting out is required on an annual basis.

Find a participating pharmacy:

- On the web: **Caremark.com/PharmacyLocator**
- Scan the QR code

Please note: You can still fill the prescriptions you take for a limited time — for example, antibiotics — at any in-network pharmacy and receive plan benefits.

PrudentRx (Traditional Plan Participants Only)

PrudentRx is available to Traditional Plan participants who take specialty drugs. PrudentRx is a prescription plan that allows participants 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:

Medical Support Programs

Provider: Blue Cross Blue Shield

Doctor on Demand (Available to Traditional + Health Savings Plan Participants)

Coworkers enrolled in either Ames medical/prescription plan can connect virtually with a licensed provider through Doctor on Demand. Virtual care is an **easy, no-cost option** for many routine healthcare needs.

Doctor On Demand makes it easy to get the care you need quickly and conveniently while helping you avoid:

- **Long wait times** — You see a doctor in minutes
- **Expensive bills** — No cost to you
- **Travel and waiting rooms** — Connect from wherever you are

Doctor on Demand is useful for:

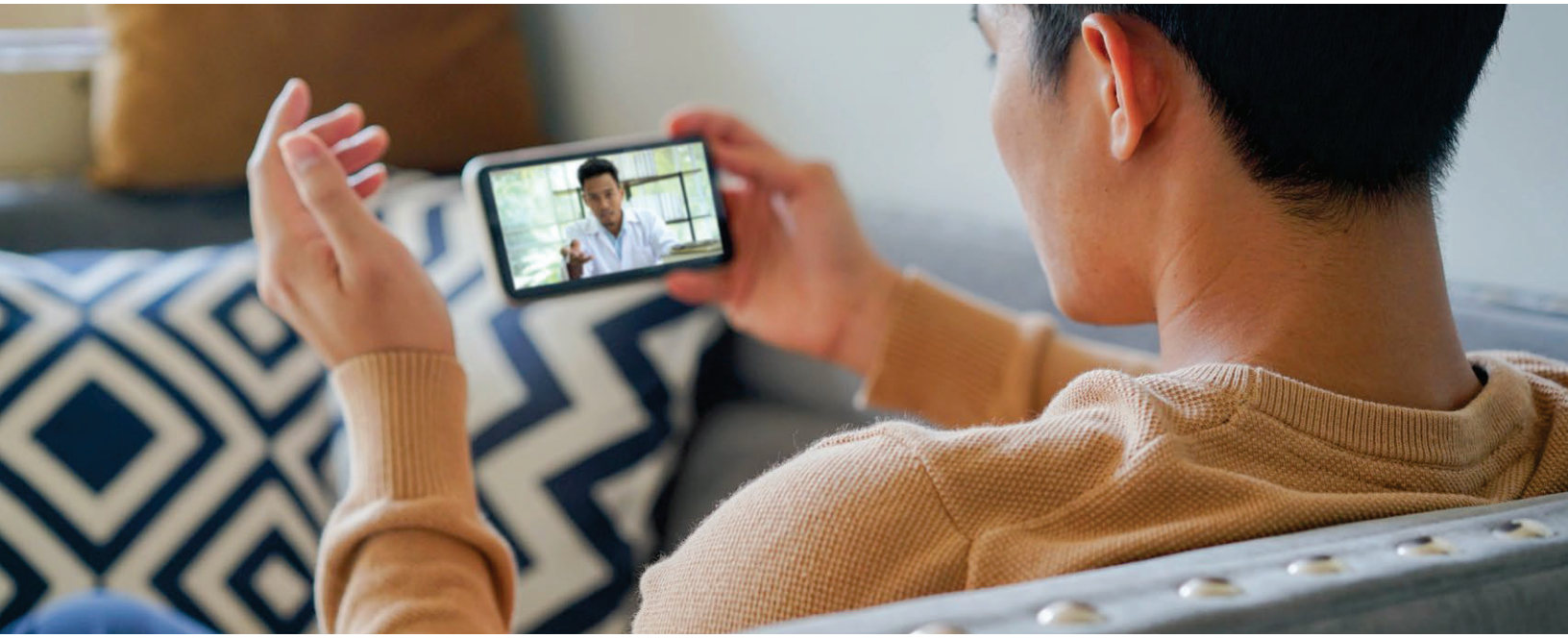
- **Minor illnesses** such as cold and flu, sinus infections, urinary tract infections, allergies, and pink eye
- **Emotional support** when you want to talk to a doctor about stress, grief, or other emotional issues

Doctors are available 24/7/365 for minor illnesses and urgent care, and your appointment can frequently start within an hour. Psychologists and psychiatrists are available by appointment the following day between 7 a.m. and 10 p.m. local time. To learn more or to sign up now, visit **DoctorOnDemand.com/BlueCrossMN.**

Blue365 Fitness Your Way (Available to Traditional + Health Savings Plan Participants)

Through Fitness Your Way, Ames medical plan participants can pay a monthly fee to access gym passes, live virtual and on-demand workouts, and discounts on healthy living services and products.

You choose the membership level that works for you. Visit **http://Blue365Deals.com/fyw** to explore the discounts and gyms in your area that participate in the program.



MEDICAL:

Health Savings Accounts

Provider: Empower

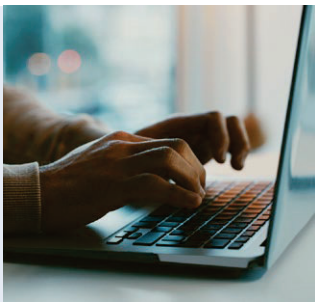
Health Savings Accounts (Available to Health Savings Participants ONLY)

The Health Savings Plan has a **higher deductible** but **lower monthly premium,** which helps you keep more money in your pocket each payday, while still providing coverage for routine and unexpected healthcare needs. In addition, it gives you access to a Health Savings Account (HSA), which allows you to save money tax-free for your healthcare expenses now or in the future. HSAs give you three ways to **lower your tax bill**:

1. Your contributions made through payroll are pre-tax, meaning they aren't subject to income taxes. For example, a $100 HSA contribution may reduce your take-home pay by only $80, depending on your tax rate and where you live.
2. If your account earns interest, the interest isn't taxed when you earn it.
3. Your withdrawals are also tax-free as long as you spend them on eligible healthcare expenses. For a full list of allowed expenses, see IRS publication 502.

Compare the Cost — and Savings!

If you choose the Health Savings Plan and contribute your premium savings to your HSA, you can build a significant balance to help cover future healthcare expenses. And you will never lose this money if you don't spend it right away. The account is yours to keep — even if you leave Ames or retire. That makes it a portable long-term investment account, not just a workplace benefit.



How Much to Contribute to your HSA

Here's how much you can contribute in 2026 and 2027. The maximum amount you can contribute each year includes both the Ames contribution and yours.

Coverage level	Ames annual contribution *(distributed monthly)*	2026 total allowable contribution	Amount you can contribute in 2026	2027 total allowable contribution	Amount you can contribute in 2027
Employee Only	$1,500	$4,400	$2,900	$4,500	$3,000
Employee + Spouse	$3,000	$8,750	$5,750	$9,000	$6,000
Employee + Child(ren)	$3,000	$8,750	$5,750	$9,000	$6,000
Employee + Family	$3,000	$8,750	$5,750	$9,000	$6,000
If you are 55 or older, **you can increase your contribution by $1,000**.					

Note: Open Enrollment will reflect the 2026 HSA allowable contributions. You may submit a change form in December to increase your paycheck contributions for 2027.

MEDICAL:

Health Savings Accounts

Provider: Empower

Using the Money in Your HSA

Money in your HSA can be used:

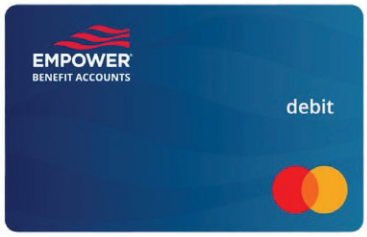
- Now for medical, dental, or vision expenses
- After you leave Ames for COBRA premiums
- At any time in the future — even after retirement — for qualified medical, dental, or vision expenses. **Your HSA balance rolls over every year**. This makes it ideal for long-term investing, not just short-term expenses.

The HSA Debit Card

If you enroll in an HSA, you will be issued a debit card and be given the option to order debit cards for your eligible dependents. The debit card provides a convenient, automatic way to pay for qualified healthcare expenses directly using the money in your account. It is important, however, to save your itemized receipts in case you are asked to prove that the expense is legitimate.

If you want to check on your balance or see what expenses have been paid from your HSA you can:

- Log into the Empower website at **www.empowermyretirement.com**
- Call Empower at 844-465-4455
- Download the Empower Benefit Accounts app from the Apple App Store or Google Play



Investing Your HSA

Investing your HSA money can be a powerful way to build long-term savings — especially for healthcare expenses in retirement. Your HSA already has a major advantage: contributions, earnings, and qualified withdrawals are tax free. When you invest your HSA funds, any growth from those investments is also tax free.

Empower, our HSA platform, simplifies investing by offering built-in investment fund options inside the HSA. The HSA is connected to your retirement account platform, so you can view balances, manage investments, and track growth — all in one place.

Eligibility Details

In order to contribute to a Health Savings Account, you must meet the eligibility requirements:

1. You must participate in the Ames Health Savings Plan
2. You must not participate in Medicare, TRICARE, or any other healthcare plan (such as your spouse's plan) that is not also HSA-eligible
3. You cannot be claimed as a dependent on anyone else's tax form

MEDICAL:

Which Plan Is Right for You?

Need help deciding which medical plan is the best fit for you? Use the **Medical Plan Cost Comparison Tool** to estimate your total annual healthcare costs. Enter your anticipated medical and prescription expenses, and the tool will calculate your projected out-of-pocket costs, including medical plan premiums and the Ames HSA contribution.

Looking for additional guidance? The examples below show how each medical plan may cover a major illness or injury based on your coverage level.

Example 1: Employee-Only Coverage

You have a critical illness or serious injury and meet the Plan's out-of-pocket maximum. Under both options, after you meet the out-of-pocket maximum, the Plan pays 100% of your medical expenses for the rest of the year. How much will it cost you, including premiums and out-of-pocket costs?

	Health Savings Plan	Traditional Plan
	Your expenses	
Annual Premium (under $100k)	$324	$756
HSA Contribution	$432	$0
+ Out-of-Pocket Maximum (In-Network)	$5,000	$3,000
	HSA money to help pay those expenses	
- Ames HSA Contribution	- $1,500	- $0
- Your HSA Contribution	-$432	-$0
Your Total Cost	**$3,824**	**$3,756**

Note: If you contribute at least the **$432 premium savings** to your HSA, then use the full **$432** from your HSA to pay for eligible healthcare expenses, your annual net cost would be reduced to about **$3,824**.

Bottom Line: Your actual cost under both plans is about the same — even in a worst-case scenario year.

MEDICAL:

Which Plan Is Right for You?

Example 2: Employee + Children Coverage

Let's look at another situation where you meet the out-of-pocket maximum, this time using an employee + children example. How much will it cost you, including premiums and out-of-pocket costs?

	Health Savings Plan	Traditional Plan
	Your expenses	
Annual Premium (under $100k)	$648	$1,512
HSA Contribution	$864	$0
+ Out-of-Pocket Maximum (In-Network)	$10,000	$6,000
	HSA money to help pay those expenses	
- Ames HSA Contribution	- $3,000	- $0
- Your HSA Contribution	-$864	- $0
Your Total Cost	**$7,648**	**$7,512**

Note: If you contribute at least the **$864 premium savings** to your HSA, then use the full **$864** from your HSA to pay for eligible healthcare expenses, your annual net cost would be reduced to about **$7,648**.

Bottom Line: Your actual cost under both plans is about the same — even in a worst-case scenario year.

MEDICAL:

Which Plan Is Right for You?

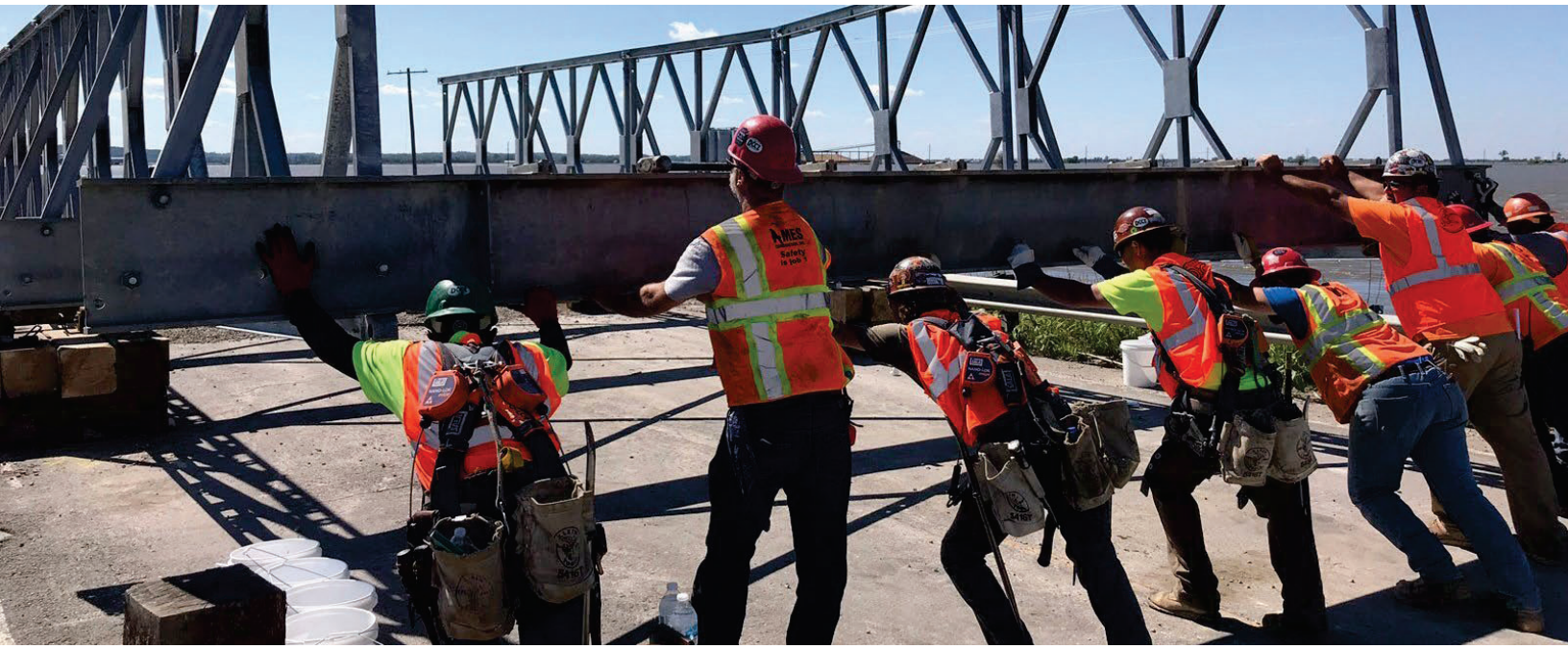
Example 3: Family Coverage

Let's look at one more situation where you hit the out-of-pocket maximum — this time using a family example. How much will it cost you, including premiums and out-of-pocket costs?

	Health Savings Plan	Traditional Plan
	Your expenses	
Annual Premium (under $100k)	$1,004.40	$2,343.60
HSA Contribution	$1,339.20	$0
+ Out-of-Pocket Maximum (In-Network)	$10,000	$6,000
	HSA money to help pay those expenses	
- Ames HSA Contribution	- $3,000	- $0
- Your HSA Contribution	-$1,339.20	- $0
Your Total Cost	**$8,004.40**	**$8,343.60**

Note: If you contribute at least your **$1,339 premium savings** to your HSA, then use the full **$1,339** from your HSA to pay for eligible healthcare expenses, your annual net cost would be reduced to about **$8,004**.

Bottom Line: You have saved more than $300 compared to the same employee who chose the Traditional Plan.



MEDICAL:

Which Plan Is Right for You?

Life is not usually a worst-case scenario

Unless you experience a major life event, you will likely spend less than the money that gets contributed to your HSA. This potentially allows you to build a tax-free balance that grows over time. If you have a year with lower healthcare expenses, the Health Savings Plan may provide even greater savings. **Why? Because you get the benefit of the lower premiums, and you still receive Ames' contribution to your HSA.**

Let's look at two employees who choose the Health Savings Plan. One has **Employee-Only coverage**, and one has **Family coverage**.

- Both employees are paying the lower premium and contribute their premium savings to their HSA account.
- Both employees have a fairly routine level of medical expenses — not a "worst-case scenario" year.
- In both cases, the money in the HSA is enough to pay for their out-of-pocket expenses and have some left over. The employees didn't have to pay a single penny out-of-pocket, because the HSA money was available to cover all of their expenses.

Plus, that left-over balance is theirs to keep and can stay in the HSA until it is needed sometime in the future.

	Health Savings Plan (with $432 HSA contribution)	Health Savings Plan (with $1,339.20 HSA contribution)
Out-of-Pocket Expenses	$1,000	$2,500
	HSA money to help pay those expenses	
- Ames HSA Contribution	- $1,500	- $3,000
- Your HSA Contribution	- $432	- $1,339.20
Total HSA balance after paying expenses	**$932**	**$1,839.20**

Bottom Line: When you pay the lower Health Savings Plan premium and contribute the difference to your HSA, you could end the year with money in the bank.

Another Use for Premium Savings

One of the great features of an HSA is that you can save unused money for expenses later on — even after retirement. But what if you expect to have higher healthcare expenses now? If you are anticipating a scheduled medical procedure or you cover dependents who frequently need medical care, you can still consider choosing the Health Savings Plan. Then you can use your premium savings to pay for Hospital Insurance, Accident Insurance, or Critical Illness Insurance. Learn more about these supplemental medical insurance options starting on page 20.

Dental Plan

Provider: Delta Dental

Note: This plan is no longer bundled with medical/prescription and vision coverage. You can now elect or decline dental coverage on its own.

Although the dental plan provides coverage whether you use in-network or out-of-network providers, choosing an in-network provider can help you save time and money because:

- **When you use in-network providers** you are charged discounted rates that the provider and the Plan agree to ahead of time.
- **When you use out-of-network providers** you pay your normal part of the cost plus amounts over the reasonable and customary (R&C) charge.
- **Network providers submit claims on your behalf,** while out-of-network claims may require you to file for reimbursement yourself.

Dental Plan Summary

The chart below gives a summary of your dental benefits.

	Dental Plan (Uses Delta Dental PPO and Premier Networks)
	When you receive dental care, you pay…
Deductible • Individual • Family	 $50 $150
Preventive and Diagnostic Care **Frequency:** • Oral exams • Full-mouth (which include bitewing) or panorex x-rays • Bitewing x-rays • Fluoride treatments	No charge, no deductible Two per calendar year One full set every 3 years Two per calendar year Two per calendar year through age 18
Basic Care, Endodontics, and Periodontics (For example, fillings, extractions, root canal therapy, periodontal treatments, denture repair)	20%
Major Care and Prosthetics (For example, crowns, inlays, onlays, dentures, fixed bridges, and implants)	50%
Annual Benefit Maximum	$2,000 per person
Orthodontia (For children age 8 to 18)	50% Separate lifetime maximum benefit: $5,000 per person

Finding In-Network Dental Providers

On the web: **http://www.DeltaDentalMN.org** and select “Find a Dentist” in the upper-right corner of the screen

On the phone: Call Delta Dental customer service at 800-448-3815

Vision Plan

Provider: Vision Service Plan (VSP)

Note: This plan is no longer bundled with medical/prescription and dental coverage. You can now choose or decline vision coverage on its own.

Vision is an important part of your overall health. To help support your eye health, vision benefits are provided through Vision Service Plan (VSP). **Note that vision exams are also covered under both medical plans.**

Our Vision Plan pays benefits whether you use an in-network provider or not. However, **you will save time and money** when you use in-network providers because:

- **When you use in-network providers,** you pay only a set copay for most services. The doctors agree ahead of time to charge discounted rates, so most of the cost is paid by the Plan.
- **When you use out-of-network providers,** you pay the full, undiscounted cost up front, and the plan reimburses you for a portion of the cost.
- **Network providers submit claims on your behalf,** while out-of-network claims may require you to file for reimbursement yourself.

Vision Plan Summary

The chart below gives a summary of your vision coverage.

	VSP Choice Plan	
	When you use an in-network provider, you pay…	*When you do not use a network provider, you pay the entire cost, and the Plan reimburses you…*
Exams		
• Routine Wellness Exam	$10	Up to $45
Glasses*		
Lenses • Single Vision Lenses • Lined Bifocal Lenses • Lined Trifocal Lenses • Lenticular Lenses • Premium progressives • Custom progressives	 $0 $0 $0 $0 $95-$105 $150-$175	 Up to $30 Up to $50 Up to $65 Up to $100
Frames	$300 plan allowance, then you pay 80% of any remaining balance	Up to $70
Contact Lenses*		
• Medically necessary contacts • Elective contacts	$0 $300 allowance plus 15% savings on contacts and the lens exam (fitting and evaluation)	Up to $210 Up to $105
How Often You Can Receive Benefits		
• Examination** • Glasses or Contact Lenses*	Once every 12 months Once every 12 months	

** You may choose either contacts or glasses once every 12 months ** Exams are also provided at no cost to you through both Ames medical plans.*

Supplemental Medical Insurance Options

Provider: Prudential

Ames offers three ways to supplement your medical insurance, whether you are insured through Ames or you have coverage elsewhere. All three supplemental medical insurance options pay benefits directly to you in cash, which you can use for expenses such as medical expenses, daycare, travel, or groceries. Premium rates can be found on page 27.

Legal, Financial, Grief Resources

If you enroll in any of the voluntary insurance options, you will also have access to Guidance Resources to help you navigate significant life changes with access to trained counselors, legal experts, and financial professionals.

Preventive Care Pays

Prudential will pay you a $50 cash benefit for each covered member who completes their preventive annual exam. Each person may receive the benefit once each year. This benefit is available for members who enroll in Critical Illness, Accident, and/or Hospital Indemnity Insurance.

If you enroll in more than one coverage, you can receive the benefit for each coverage you choose. For example, if you, your spouse, and one child are enrolled in both Accident Insurance and Hospital Indemnity insurance, and if each of you complete a qualifying preventive care service, you could receive $300 total:

- $150 preventive care benefit for your Accident Insurance coverage
- $150 preventive care benefit for your Hospital Indemnity coverage

Critical Illness Insurance

Critical Illness insurance pays a lump sum benefit if you, your covered spouse, or covered child(ren) are diagnosed with a covered illness. You can choose from three levels of coverage, which is the full coverage amount:

- $10,000
- $20,000
- $30,000

You receive the full coverage amount	
Invasive Cancer	Kidney Failure
Coronary Artery Bypass Graft	Major Organ Transplant
Diabetes (Type 1)	Alzheimer's Disease
Loss of Sight, Hearing, or Speech	Multiple Sclerosis
Heart Attack	Stroke

You receive 50% of the coverage amount	You receive 25% of the coverage amount
Non-invasive cancer	COVID-19

Supplemental Medical Insurance Options

Provider: Prudential

Accident Insurance

Prudential Accident Insurance can help to offset medical costs related to a covered accident, such as:

- Dislocations and fractures
- Burns
- Cuts requiring stitches
- Concussions

This benefit provides a fixed payment that varies based on the type and severity of the injury and whether you enroll in the Low Option or the High Option. For example, a fracture could pay a benefit from $125 to $8,000 depending on the severity of the break, which bone was broken, whether surgery was required, and other factors.

In addition, the Plan pays benefits based on other types of care you require. You can receive a benefit for specific medical care such as:

- Ambulance
- Physical therapy
- Pain management drugs

If you choose coverage for yourself, you can also choose coverage for your spouse and eligible children. For more details on what is covered and at what payment level, see the **Coverage Certificates**.

Hospital Indemnity Insurance

Hospital Indemnity Insurance can help with out-of-pocket expenses if you are hospitalized because you are sick, hurt, or even having a baby. The Plan provides payments in addition to any other insurance payments you may receive.

Benefit Type	Benefit Limits	Low Option	High Option
Hospital Admission • Non-ICU • ICU	 Once per sickness or injury Once per sickness or injury	 $500 $1,500	 $1,000 $3,000
Hospital Daily Benefits (starting day one) • Non-ICU • ICU	 Up to 365 days/year Up to 30 days/admission	 $100 $300	 $200 $600
Inpatient Accident Rehabilitation	Up to 30 days/calendar year	$100	$100
Newborn Confinement	Up to 3 days/confinement	$100	$200

When you choose coverage for yourself (either the Low Option or High Option) you can also choose to cover your spouse and/or your child(ren).

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

Provider: Prudential

Planning for the future isn't always an easy conversation, but it's an important one. Life insurance can provide financial protection and peace of mind by helping ensure your loved ones are supported if something unexpected happens.

Ames provides **Basic Life and AD&D Insurance** to give you a base level of protection for you and your loved ones in the event of a serious injury or death. In addition, you may purchase **Supplemental Life and AD&D Insurance** for yourself and your eligible dependents.

The chart below gives a summary of your life and AD&D insurance options. This coverage is provided by Prudential.

Basic Life and AD&D Insurance for you (provided by Ames)	$50,000 **Notes:** • Life insurance pays a benefit if you die while you are employed by Ames. • AD&D insurance pays a benefit if you die or are seriously injured in an accident while you are employed by Ames. • Coverage is automatic and paid in full by Ames.
Supplemental Life and AD&D Insurance for Yourself	$10,000 - $500,000 • In increments of $10,000 • No more than 5x your base annual salary **Notes:** • If you enroll when you first become eligible, you can choose up to $100,000 in coverage and you will not have to answer medical questions. Additional coverage will require proof of good health. • During Open Enrollment, you can increase coverage by $20,000 (up to $100,000 in coverage) without answering medical questions. • Proof of good health is required for higher amounts.
Supplemental Dependent Life and AD&D Insurance for Your Spouse	$5,000 - $100,000 • In increments of $5,000 • Coverage cannot be more than 50% of the supplemental life insurance amount you choose for yourself. **Notes:** • If you enroll your spouse when you first become eligible, you can choose up to $25,000 in coverage and your spouse will not have to provide proof of good health. • If you enroll later or want to increase your coverage, your spouse will have to provide proof of good health.
Supplemental Dependent Life and AD&D Insurance for Your Child(ren)	$1,000 - $10,000 • In increments of $1,000 **Notes:** • You will not have to answer health questions about your children. • Life insurance for children can begin after a live birth and ends when the child reaches age 26. • One premium covers all of your eligible children, regardless of how many are enrolled.

Note: You will not be required to designate a beneficiary for spouse or child life insurance. Employees are automatically assigned to be the beneficiary for these benefits.

Other Benefits
Not Impacted by Open Enrollment

Ames offers several benefits that are automatically available to you. Because these benefits are employer-paid, you do not need to enroll during Open Enrollment.

Disability Insurance

Ames provides both short-term and long-term disability insurance coverage for all non-work-related illnesses or injuries at no cost to you.

- **Short-term disability** benefits begin after a one-week waiting period. You will receive 70% of your base wage (up to $2,100 per week) for up to 11 weeks while you are unable to work. New employees are eligible for this benefit after they have worked at Ames for 90 days.
- **Long-term disability** benefits begin when short-term disability benefits end. You will receive 50% of your base wages up to $10,000 per month as long as you continue to qualify for benefits.

Mental Health Benefits

Ames partners with Lyra to provide mental and emotional health support services to all Ames coworkers, whether or not you participate in the Ames medical plan. Through Lyra, you and each of your immediate family members can receive:

- Up to 10 free mental health coaching or therapy sessions each year with providers that are matched to you based on your needs and preferences
- Personalized care plans developed by mental health professionals that you can work through on your own
- On-demand resources to help with stress management, sleep, and overall well-being

Retirement Plan

Through the **401(k) Plan**, you can contribute money to your retirement account, and Ames matches a portion of your contribution. You can choose between making traditional (pre-tax) and Roth (after-tax) contributions, or a combination of the two. Through the **Profit Sharing Plan**, Ames shares a portion of the company's profits with participants in the Profit Sharing Plan.

Employee Stock Ownership Plan (ESOP)

Every day, our coworkers help build Ames' success. Through the Employee Stock Ownership Plan (ESOP), coworkers have the opportunity to share in that success as employee-owners while building long-term financial security.

Other Benefits
Not Impacted by Open Enrollment

Hinge Health Virtual Physical Therapy

All Ames coworkers have access to Hinge Health when you have aches, pains, or are recovering from an injury. Hinge Health is virtual physical therapy guided by real physical therapists who develop a personalized program to help you recover and feel better.

Paid Time Off and Paid Holidays

Ames coworkers earn paid time off, which can be used for vacation, sick time, or any other personal reason. The amount you earn each month depends on how many years you have worked at Ames. In addition to paid time off, Ames recognizes eight paid holidays each year. Additional details can be found on the **Benefits Resource site**.

Leaves of Absence

- **Family and Medical Leave —** All Ames employees are eligible for federally protected leave after meeting the requirements described in the Family and Medical Leave Act (FMLA).
- **Military Leave —** Ames appreciates the sacrifices our service members make. For up to one year, Ames offers differential pay and benefits coverage when a coworker leaves to serve in the military.
- **Parental Leave —** Ames employees are eligible for paid leave after the birth or adoption of their child.
  - The birth parent (or primary caregiver in the case of adoption) is eligible for six weeks of paid leave.
  - The non-birth parent (or secondary caregiver, in the case of adoption) is eligible for one week of paid leave.

Ames Perks – BenefitHub

BenefitHub provides convenient access to a wide range of discounts, including savings on auto and home insurance, pet insurance, travel, hotels, and event tickets. The platform features discounts from both national brands and local businesses.

What Do These Terms Mean?

Healthcare insurance terms

Balance billing: The amount you are billed to make up the difference between what an out-of-network provider charges and what insurance reimburses. This amount does not count toward the out-of-pocket maximum.

Coinsurance: The percentage of covered expenses you pay after the deductible (if applicable) is met and before you reach the out-of-pocket maximum.

Deductible: The dollar amount you are responsible for paying each plan year before insurance begins contributing towards paying claims.

Formulary: Pharmacy programs issue a list of prescription drugs that are covered by the Plan and sort them into categories such as generics, preferred name brand, and non-preferred name brand. This list is called a formulary.

Maintenance medication: Maintenance medications are designed to be taken regularly over a long period of time to treat or prevent a chronic condition. Examples include cholesterol-lowering medication, birth control, and anti-depressants.

Network: Healthcare plans contract with specific lists of providers and facilities to provide services at discounted costs. The providers and facilities trade these discounts for preferred access to large numbers of potential patients. In-network care is far less expensive than out-of-network care. When you use providers outside the network, you may receive a balance bill or balance-due bill. (See “balance billing” above.)

Out-of-pocket maximum: The most you pay during the calendar year for covered expenses. This includes copays, deductibles, coinsurance, and prescription drugs.

Preventive care: Care designed to detect abnormalities and disease before they become larger problems. Generally, preventive care is covered 100% when you use in-network providers.

In a medical plan, this generally includes:

- Annual physicals/well-woman exams/ well-child and well-baby care
- Immunizations
- Mammograms/colonoscopies/prostate exams
- PSA tests/pap smears
- Some prescription drugs that are used to stabilize or prevent a chronic condition

In a dental plan, this generally includes:

- X-rays and cleanings
- Fluoride treatments (generally only in children)

Life insurance terms

Accidental Death and Dismemberment (AD&D): AD&D Insurance provides a benefit if a covered person is seriously injured or dies as the result of an accident.

Evidence of Insurability (EOI): Some insurance coverage requires proof of good health for coverage to be approved. This process is known officially as evidence of insurability and it usually consists of a series of medical questions you answer, sometimes with your doctor’s help.

Guarantee Issue (GI): The amount of added life insurance available to purchase, usually as a new hire, without having to answer medical questions.

Benefit Cost Breakdown

Health Savings Plan Medical/Prescription Rates

Coverage Tier	Employee Monthly Contribution	Ames Monthly Contribution	Total Monthly Cost
Base pay under $100K			
Employee Only	$27.00	$1,041.21	$1,068.21
Employee + Spouse	$72.90	$2,629.43	$2,702.33
Employee + Child(ren)	$54.00	$1,988.09	$2,042.09
Family	$83.70	$3,090.24	$3,173.94
Base pay $100k - $199k			
Employee Only	$45.00	$1,023.21	$1,068.21
Employee + Spouse	$121.50	$2,580.83	$2,702.33
Employee + Child(ren)	$90.00	$1,952.09	$2,042.09
Family	$139.50	$3,034.44	$3,173.94
Base pay over $200k			
Employee Only	$67.50	$1,000.71	$1,068.21
Employee + Spouse	$182.25	$2,520.08	$2,702.33
Employee + Child(ren)	$135.00	$1,907.09	$2,042.09
Family	$209.25	$2,964.69	$3,173.94

Traditional Plan Medical/Prescription Rates

Coverage Tier	Employee Monthly Contribution	Ames Monthly Contribution	Total Monthly Cost
Base pay under $100K			
Employee Only	$63.00	$1,022.13	$1,085.13
Employee + Spouse	$170.10	$2,651.23	$2,821.33
Employee + Child(ren)	$126.00	$1,935.74	$2,061.74
Family	$195.30	$3,168.59	$3,363.89
Base pay $100k - $199k			
Employee Only	$94.50	$990.63	$1,085.13
Employee + Spouse	$255.15	$2,566.18	$2,821.33
Employee + Child(ren)	$189.00	$1,872.74	$2,061.74
Family	$292.95	$3,070.94	$3,363.89
Base pay over $200k			
Employee Only	$144.00	$941.13	$1,085.13
Employee + Spouse	$388.80	$2,432.53	$2,821.33
Employee + Child(ren)	$288.00	$1,773.74	$2,061.74
Family	$446.40	$2,917.49	$3,363.89

Benefit Cost Breakdown

Dental Rates

Coverage Tier	Employee Monthly Contribution	Ames Monthly Contribution	Total Monthly Cost
Employee Only	$3.00	$32.04	$35.04
Family	$10.00	$111.75	$121.75

Vision Rates

Coverage Tier	Employee Monthly Contribution	Ames Monthly Contribution	Total Monthly Cost
Employee Only	$1.00	$5.69	$6.69
Family	$3.00	$15.50	$18.50

Voluntary Life and AD&D Rates

Age as of October 1, 2026	Monthly Rate per $1,000 coverage	
	Employee Coverage	Spouse Coverage
Under 30	$0.139	$0.128
30-34	$0.145	$0.134
35-39	$0.183	$0.172
40-44	$0.246	$0.235
45-49	$0.371	$0.360
50-54	$0.583	$0.572
55-59	$0.878	$0.867
60-64	$1.351	$1.340
65-69	$2.185	$2.174
70+	$4.066	$4.055
Child Life and AD&D	$0.257	

Accident Insurance Rates

Coverage Tier	Low Plan Monthly Rate	High Plan Monthly Rate
Employee Only	$4.78	$6.77
Employee + Spouse	$9.55	$13.53
Employee + Child(ren)	$11.62	$16.50
Family	$13.68	$19.40

Hospital Indemnity Insurance Rates

Coverage Tier	Low Plan Monthly Rate	High Plan Monthly Rate
Employee Only	$6.91	$12.33
Employee + Spouse	$19.12	$33.38
Employee + Child(ren)	$11.65	$20.87
Family	$23.86	$41.92

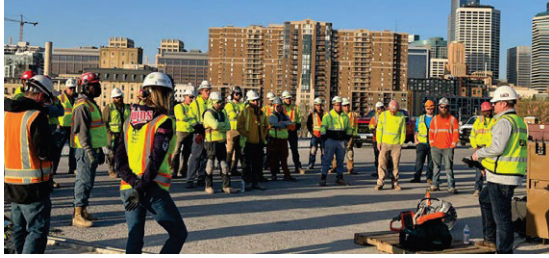
Critical Illness Insurance

Age as of October 1, 2026	Monthly Rate per $1,000 coverage			
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Under 25	$0.306	$0.619	$0.451	$0.764
25 - 34	$0.411	$0.847	$0.557	$0.992
35 - 44	$0.750	$1.541	$0.895	$1.686
45 - 54	$1.468	$2.823	$1.613	$2.968
55 - 64	$2.517	$4.581	$2.662	$4.727
65 +	$3.928	$6.977	$4.073	$7.122

Helpful Contacts

Plan	Carrier & Important Info	Phone	Website
Medical	Blue Cross and Blue Shield of Minnesota	Call the number on the back of your ID card or Member Services: 866-873-5943	BlueCrossMN.com
Prescription Drugs	CVS Caremark	877-264-2955	Caremark.com
Virtual Medical Care	Doctor on Demand	N/A	DoctorOnDemand.com/ BlueCrossMN
Health Savings Account	Empower	844-465-4455	EmpowerMyRetirement.com
Dental	Delta Dental of Minnesota	800-448-3815	DeltaDentalMN.org
Vision	Vision Service Plan (VSP)	800-877-7195	VSP.com
Voluntary Accident Insurance	Prudential	844-455-1002	MyBenefits.Prudential.com
Voluntary Critical Illness Insurance	Prudential	844-455-1002	MyBenefits.Prudential.com
Voluntary Hospital Indemnity	Prudential	844-455-1002	MyBenefits.Prudential.com
Basic Life and AD&D Insurance	Prudential	888-227-6764	MyBenefits.Prudential.com
Voluntary Life and AD&D Insurance	Prudential	888-227-6764	MyBenefits.Prudential.com
Mental Health Benefits	Lyra	877-849-1353 Hay consejeros de habla hispana disponibles	AmesConstruction.LyraHealth.com
Virtual Physical Therapy	Hinge Health	855-902-2777	https://Hinge.Health/ AmesConstruction
401(k) Retirement	Empower	844-465-4455	EmpowerMyRetirement.com
Profit Sharing Plan	Empower	844-465-4455	EmpowerMyRetirement.com
Discounts & Perks	BenefitHub	N/A	AmesPerks.BenefitHub.com Enter referral code: 7NMUCL

Legal Notices



Patient Protection Model Disclosure

Ames Construction generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Blue Cross Blue Shield of MN at 866-873-5943.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Blue Cross Blue Shield of MN or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Blue Cross Blue Shield of MN at 866-873-5943.

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 or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. 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 therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Ames Construction, Inc. coverage 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.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Ames Construction, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact 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 of this notice at any time.

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

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	October 1, 2026
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:	AmesBenefits@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.

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, 2025.

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.

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.

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

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.

Uses and Disclosures of Substance Use Disorder Records: Certain health information the Plan may receive and maintain may be protected under a federal law called 42 CFR Part 2, which provides extra protections for substance use disorder (SUD) treatment records maintained by Part 2 programs, as defined under 42 CFP Section 2.11. These records may be related to the diagnosis treatment, or referral for treatment for a substance use disorder.

In the event the Plan were to obtain SUD treatment records from a Part 2 program, the Plan may use or disclose your SUD records only as allowed under 42 CFR Part 2, and in most cases only with your written consent obtained by the Part 2 program. Once you sign the written consent, your SUD information may be used or disclosed for the following purposes:

- For treatment, payment, or health care operations
- To your health plan or other providers that help coordinate your care
- To contractors or business associates working on the Plan's behalf

SUD treatment records received from Part 2 programs shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against the individual unless based on written consent, or a court order after notice and an opportunity to be heard is provided to the individual or the holder of the record, as provided under 42 CFR Part 2.

Your written consent is valid until you revoke it in writing, unless you set an earlier expiration date. If you revoke your consent, the Plan will no longer share your information, except where already used or disclosed. If you give consent to a Part 2 program to share your SUD records for the purposes listed above, the information the Plan shares may not be redisclosed by the recipient unless the recipient is subject to HIPAA or 42 CFR Part 2 or you explicitly give them written permission to redisclose the information.

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.

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 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.

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.

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
AmesBenefits@amesco.com

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
AmesBenefits@amesco.com

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

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."

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.

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
AmesBenefits@amesco.com

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
AmesBenefits@amesco.com

Newborns' and Mothers' Health Protection Act

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.
If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. 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: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ 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

GEORGIA – Medicaid	ILLINOIS - 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	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	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	**MAINE – Medicaid**
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	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	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840, TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid	NEVADA – Medicaid
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
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	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since July 31, 2026, 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 5/31/2029)

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.