Welfare Benefit Plan
Summary Plan Description

WRAP Plan

Ames Construction Health and Welfare Plan

For Non-Union Employees

SOLICITUD DE INFORMACIÓN EN ESPAÑOL (SPANISH LANGUAGE OFFER OF ASSISTANCE)

Este documento del plan está escrito en inglés y contiene un resumen de sus derechos y beneficios bajo este plan de beneficios para empleados. Si tiene dificultades para comprender alguna parte de este documento del plan, comuníquese con su Representante de Recursos Humanos al 952-435-7106 (durante las horas normales de trabajo) para obtener ayuda.

WRAP Plan

Summary Plan Description

Plan Name: Ames Construction Health and Welfare Plan

Your Employer has adopted the health and welfare benefit plan named above ("the Plan") to provide you and other Employees health and welfare benefits. The Plan provides various benefits through its Plan Components.

The Plan is required to comply with certain federal laws and regulations that may change with the passage of new or revised laws. As such, your Employer has the right to amend the provisions of the Plan to comply with federal regulation and for any other reason. If the Employer makes changes to the Plan, you will be notified about changes affecting your rights under the Plan.

This Summary Plan Description (SPD) summarizes the important features of the Plan document, including your benefits and obligations under the Plan. Read this SPD carefully so that you understand the provisions of the Plan and the benefits you will receive. These benefits are provided under various insurance contracts, service providers or through self-insurance. The Benefit Documents for each Plan Component are incorporated herein by reference only to the extent it provides detailed descriptions regarding each Plan Component's eligibility rules, benefit descriptions, claims and appeal procedures, or other substantive provisions.

Certain terms in the SPD have a special meaning when used in the Plan. These terms are capitalized throughout the SPD and are defined in more detail in the DEFINITIONS section of the SPD. If any information in this SPD conflicts with the terms of the Plan document, the terms of the Plan document – not this SPD – will apply.

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EMPLOYER INFORMATION

Who established the Plan?

The official name of the Plan is:	Ames Construction Health and Welfare Plan
Plan Number:	505
The Employer who adopted the Plan is:	Ames Construction, Inc.
Business Address:	2500 County Road 42 West Burnsville, MN 55337
Business Telephone Number:	952-435-7106
Federal Tax Identification Number:	41-0871375
Tax Year End:	December 31

Additional Related Employers have adopted the Plan. You may obtain a complete list of the Related Employers adopting the Plan and their relationship to your Employer by submitting a written request to your Plan Administrator.

EFFECTIVE DATES

Establishment of New Plan

This Plan replaces Plan Nos. 501 and 502, combining all benefits previously covered by those plans under this Plan No. 505.

The Plan shall take effect on: October 1, 2022

ELIGIBILITY

Q1. Who is eligible for benefits?

You are eligible to participate in the Plan the first day of the next month following your date of hire if you are a:

- Full-Time Employee
- Retiree

and meet certain criteria, as provided in Appendix B and C.

Q2. Are my Dependents eligible to be covered by the Plan?

Yes, Dependents can be covered by the Plan. The following individuals are considered Dependents.

- Your lawfully married spouse possessing a marriage license who is not divorced from you. For purposes of this section, "marriage or married" means a union that is legally recognized as a marriage under the state law where such marriage was performed;
- Your common-law spouse based upon a common-law marriage which is legally recognized in the jurisdiction in which your principal residence is located;
- Your Dependent Child(ren).

  Please Note: For the Major Medical/Prescription Component, your Dependent Child is covered until the Adult Child reaches the age of 26. For all other Plan Components, your Dependent Child may have to comply with other requirements. See Appendix B for additional information.

  If your Dependent Child is physically or mentally disabled, coverage for the Child may continue beyond the age of 26, provided the Child's disability begins before the date the Child reaches the age at which coverage would otherwise end. You will need to provide proof of your Child's disability to the Plan Administrator at least **60 days** before the date coverage in Appendix B ends, and annually thereafter.

Q3. How do I enroll in benefits?

Once you meet the eligibility criteria, you may enroll in benefits as of the first day of the next month following your date of hire, unless otherwise indicated in the Plan Component. *See* Appendix B for additional information.

To enroll, follow the procedures below:

- ***Initial Enrollment***

  If you are eligible to participate in the Plan, you have 30 days from your date of hire, the date you are first eligible for benefits, or the date of a qualifying life event to submit your elections and any supporting documents, if applicable. If you miss your enrollment period, you will have to wait until the next open enrollment period or experience a qualifying

life event to enroll in the Plan.

- ***Annual Open Enrollment***

  You may change your benefit elections (or enroll in the Plan if you did not enroll when first eligible) during each annual open enrollment period. You should review the enrollment materials provided to you and follow the instructions for enrolling or re-enrolling, as applicable. If you do not properly complete enrollment on a timely basis, your elections for the prior Plan Year may cease or remain the same for the subsequent Plan Year.

Q4. Can I change benefits throughout the year?

Yes, you may be eligible to enroll in a Major Medical/Prescription Component under certain circumstances.

If you initially declined coverage or are enrolled in coverage, but wish to change your enrollment, the Plan provides special enrollment periods that allow you to either elect coverage or change your coverage. You must make a written request to Human Resources within the applicable time frame.

The Plan provides the following special enrollment periods (i) loss of other coverage; (ii) acquisition of a new Dependent through marriage, birth, adoption, or placement for adoption; and (iii) change in coverage under a State's Children's Health Insurance Program ("CHIP"). Please refer to the applicable Component Document for additional information.

Q5. When does coverage begin and end?

Coverage begins on the eligibility date and ends either on the termination date or at the end of calendar month of the termination date, as described in the Plan Component. *See* Appendix B for additional information.

Generally, coverage will end because of divorce, death, change in employment status (including termination), failure to pay contributions, the Dependent Child reaches the age of 26, or a Plan amendment or termination.

Q6. What should I do if a Covered Dependent loses eligibility status?

You are required to notify Human Resources in writing within 60 days of a Dependent's change in status. If you fail to notify the Plan Administrator when a Covered Dependent becomes ineligible for coverage, you may be required to reimburse the Plan for costs incurred by the Plan and the Plan Administrator may take other action, as permitted by the Plan.

Please note that coverage for that Dependent will end on the date of the event, as provided in the Plan Document. For example, if you cover a spouse as a Dependent in the Health Care Component, the spouse's coverage will end on the date of the divorce, even if you notify the Plan much later.

PLAN COMPONENTS AND FUNDING

Q1. What is the purpose of the Plan?

The Plan is a welfare benefit plan that is intended to provide a range of benefits to promote your health and welfare.

Q2. What is the Plan funding method?

The Plan is funded through *(select all that apply)*

- insured contracts.
- self-insured arrangements paid through the general assets of the Employer.

Q3. What is the source of contributions?

- Employer Contributions
- Employee Contributions

Q4. How do I pay for benefits?

The cost of benefits is deducted from your pay on a:

- Pre-tax basis. As a result, the pre-tax payment or contribution will reduce your taxable income. For additional questions regarding pre-tax payment or contributions, please speak to a tax or legal advisor.
- Post-tax basis.

Note: The inclusion of your Domestic Partner in coverage, if permitted under the Plan, may not be tax deductible. Please consult with a tax or legal advisor for additional information.

BENEFITS

Q1. What benefits are provided under the Plan?

The Plan provides the following benefits:

- Major Medical
- Prescription
- Dental
- Vision
- Long Term Disability
- Short Term Disability
- Basic Life
- Voluntary Life
- Basic Accidental Death & Dismemberment
- Health Savings Account
- Voluntary Worksite Benefits (Accident, Critical Illness, Hospital Indemnity)
- Employee Assistance Program

CLAIMS

Q1. How do I appeal a Claim or benefit determination?

If you disagree with a benefit or Claims determination, you must submit a written request to the Claims Administrator. Please see Appendix A for the contact information, including address of the Claims Administrator for the Plan Component.

Q2. Are there specific procedures for each Plan Component regarding appeals?

Yes, each Plan Component is governed by policies and procedures contained in its respective Plan Document(s). In addition, federal law requires that certain medical claims and disability claims be administered in a particular manner. Please review the sections below as applicable to a Health Care Component and a Disability Component.

Q3. What if a Plan Component does not have an appeal policy or procedure or is not a Health Care or Disability Component?

If a Plan Component does not contain an appeal policy or procedure, the terms of the Plan Document will govern.

Generally, any Plan Component will review a Claim within 90 days and provide written notification of its decision. The 90-day period may be extended by 90-days in certain circumstances. If you disagree with the Claim decision, you may file an appeal within 60 days of your receipt of the written notice of denial of a Claim. The Plan administrator will then render a decision within 60 days after receipt of the request for review. In special circumstances, the Plan may make a determination within 120 days after the receipt of your request for review. If such an extension is required, you will be notified in writing.

HEALTH CARE COMPONENT

Q4. What types of Claims can I appeal?

You can appeal any Claim for benefits, which includes a request for coverage determination, a pre-authorization or approval of a Plan benefit, or a utilization review determination in accordance with the terms of the Plan. Depending on the type of Claim, your Claim will fall into one of the following categories:

- *Post Service Claims* – are those Claims that are filed for payment of benefits after health care has been received.
- *Pre-Service Claims* – are those Claims that require notification or approval prior to receiving health care.
- *Urgent Care Claims* - are those Claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or that could cause severe pain.
- *Concurrent Care Claims* – are those Claims that were previously approved for treatment.

Q5. Are there applicable time periods to submit Claim and to receive a response?

Yes, please follow the chart for applicable time periods:

	Post-Service and Pre-Service Claims	Urgent Care Claims
Notification of whether Claim is accepted or denied	30 days	72 hours
Extension due to matters beyond the control of the Plan	15 days	N/A
Insufficient information to process the Claim		
Notification to Participant	15 days	24 hours

Response by Participant	45 days	48 hours
Review of Claim denial	15 days	48 hours

Please Note: For concurrent care Claims, if the treatment was previously approved, the request to extend the treatment will be processed within 24 hours of the receipt of the request, if the request is made 24 hours prior to the end of the approved treatment. However, if the request is not made at least 24 hours prior to the end of the approved treatment, the request will be processed as an urgent care Claim.

Q6. If my Claim is denied, will I receive a notification?

Yes, if your Claim is denied in full or in part, you will receive a written notice of adverse benefit determination. The notice will contain the following information:

(a) Information sufficient to identify the Claim.
(b) The specific reason(s) for the denial.
(c) Reference to the specific Plan provisions on which the denial was based.
(d) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
(e) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under ERISA Section 502 following a denial on review, if applicable.
(f) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim;
(g) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the Claimant upon request;
(h) If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either (i) an explanation of the scientific or clinical judgment for the determination, or (ii) a statement that such explanation will be provided free of charge, upon request;
(i) If the denial involves an urgent care Claim, the notice will also include a description of the expedited review process applicable to such Claims.

Q7. Is there anything the Plan must do in regards to the notice of adverse benefit determination?

Yes, the Plan is required to take the following steps:

- Ensure that any notice includes information sufficient to identify the Claim, including the date of service, the health care provider, and the amount of the Claim. Moreover, the Plan must provide notice of the opportunity to request the diagnosis code, the treatment code, and its corresponding meaning;
- Ensure the notice includes the denial code and its corresponding meaning and the standard used to deny the Claim;
- Provide a description of the internal appeal and external review processes available under the Plan;
- Provide a description of how to initiate an appeal; and
- Disclose the availability of any applicable office of health insurance consumer assistance or ombudsman available to assist with internal Claims and appeals or external review processes, including contact information.

Q8. If my Claim is denied, what should I do?

When you receive a denial, you will have **180 days** following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

(a) was relied upon in making the Claim determination;
(b) was submitted, considered, or generated in the course of making the Claim determination, without regard to whether it was relied upon in making the Claim determination;
(c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that Claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all Claimants; or
(d) constituted a statement of policy or guidance with respect to the Plan concerning the denied Claim.

The review will take into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Claim determination. The review will not afford deference to the initial denial and will be conducted by a Fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

Q9. Is there an expedited process for an urgent care Claim?

Yes, you are entitled to an expedited review process that permits you to submit your request orally or in writing and that permits all necessary information to be shared by telephone, facsimile, or other similarly expeditious method.

Q10. If I appeal a Claim determination, what happens next?

Once you have submitted an appeal, you will receive a written response, as follows:

	Pre-Service Claims	Post-Service Claims
First Level Appeal – notification to Participant	15 days	30 days
Appeal by Participant	15 days	15 days
Second Level Appeal – notification to Participant	15 days	30 days

Q11. Will I receive a written notification of a claim determination on review (i.e., an appeal)?

Yes, you will receive a Final Notice of Adverse Benefit Determination. The notice will include the following information:

(a) Information sufficient to identify the Claim.
(b) The specific reason(s) for the denial.
(c) Reference to the specific Plan provisions on which the denial was based.
(d) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
(e) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under ERISA Section 502 following a denial on review, if applicable.
(f) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim;
(g) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the Claimant upon request;
(h) If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either (i) an explanation of the scientific or clinical judgment for the determination, or (ii) a statement that such explanation will be provided free of charge, upon request; and
(i) The following statement, “you and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.”

Q12. If my appeal is denied, do I have any other rights?

Yes, you may have the right to request an independent, external review. Your external review will be conducted by an independent review organization not affiliated with the Plan. This independent review organization may overturn the Plan’s decision, and the independent review organization’s decision is binding on the Plan. your appeal denial notice will include more information about your right to file a request for an external review and contact information. You must file your request for external review within four months of receiving your final internal appeal determination. Filing a request for external review will not affect your ability to bring a legal claim in court. When filing a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

Q13. Can I file a lawsuit against the Plan, the Employer, the Plan Administrator or any other entity?

Yes, but you must first follow the claims procedures outlined in the Plan Component and receive a final determination from the Plan Administrator. Moreover, if you wish to file your claim in court, you must do so within one year from the date you receive the Final Notice of Adverse Benefit Determination.

DISABILITY COMPONENT

Q14. When will I receive a claim determination?

You will receive a written or electronic notification of the Plan’s Claim decision within 45 days.

Q15. Will the claim determination period ever be extended?

Yes, the Plan may extend the review period twice, each time by 30 days, if the extension is necessary due to circumstances beyond the control of the Plan. If an extension is necessary, the Plan will notify you in writing.

Q16. What if I didn't submit all the necessary information to process my claim?

The Plan will send you a written notice and will provide a description of the required documents or information. You will then have 45 days to submit the additional information to the Plan.

Q17. Will I receive a notice if my claim is denied?

Yes, you will receive a notice that will contain the following information:

(a) Information sufficient to identify the Claim.
(b) The specific reason(s) for the denial.
(c) Reference to the specific Plan provisions on which the denial was based.
(d) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
(e) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under ERISA Section 502 following a denial on review, if applicable.
(f) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim; and
(g) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the Claimant upon request.

Q18. If my Claim is denied, what should I do?

When you receive a denial, you will have **180 days** following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Q19. If I appeal a Claim determination, what happens next?

Once you have submitted an appeal, you will receive a written response within 45 days after receipt of your request to review a claims determination. The 45-day period may be extended by 45 days if the Plan determines that special circumstances require an extension. If an extension is required, you will receive a written notification.

COORDINATION WITH OTHER PLANS

Q1. What happens if I am covered by two or more health plans?

Coordination of benefits is governed by the Plan Document applicable to each Plan Component. To the extent the Plan Component does not contain a provision affecting coordination of benefits, this Plan and any of its Plan Components will be secondary payor. In addition, if you are enrolled in an HRA Component, the HRA Component will be payor of last resort.

Q2. What if the other health plan is a high deductible health plan ("HDHP")?

If the other health plan is a HDHP, the Major Medical Component will not pay any benefits. This applies even if those benefits are not covered by the HDHP. See Appendix A for the list of the Major Medical Components.

Q3. What if the other health plan is Medicare?

If the other health plan is Medicare, this Plan will be primary unless you have chosen Medicare as your primary plan or unless required by law.

Q4. Will the Plan be primary or secondary payer if I am covered by Medicare?

If you are covered by Medicare, the Plan intends to pay either primary or secondary as follows.

- If you are 65 or older and the Employer has less than 20 employees, Medicare will be the primary payer.
- If you are 65 or older and the Employer has more than 20 employees, Medicare is the secondary payer.
- If you are disabled and the Employer has 100+ employees, Medicare is the secondary payer.
- If you have End Stage Renal Disease (ESRD) and you are in the first 30 months of Medicare entitlement, Medicare is

the secondary payer during the 30-month coordination period.

- If you have ESRD and are covered by COBRA continuation coverage and you are in your first 30 months of Medicare entitlement, Medicare is the secondary payer during the 30-month coordination period.
- If you are 65 or older and are covered by Medicare and COBRA continuation coverage, Medicare pays primary and COBRA pays secondary.
- If you are disabled and covered by Medicare and COBRA, Medicare pays primary and COBRA pays secondary.

Q5. What is Medicare entitlement?

Medicare entitlement refers to the period when you are *enrolled* in Medicare, not when you are *eligible* to enroll. Contact Medicare directly with questions regarding eligibility and/or enrollment.

GENERAL INFORMATION ABOUT THE PLAN

Q1. What should I do if I want to pursue a legal action against the Plan?

You must first exhaust the claims procedure applicable to the Plan Component. Thereafter, you may file a lawsuit in the state or federal court in Minnesota.

Q2. If I need to take legal action that involves the Plan, who is the agent for service of legal process?

The individual named below can be served with legal papers regarding the Plan.

Ames Construction, Inc.
Attn: Chief Legal Counsel
2500 County Road 42 West
Burnsville, MN 55337

Q3. What is the time limit to bring a lawsuit?

Please refer to the applicable Plan Component for information about the time period applicable to your claim. If the Plan Component does not contain any such provision, as permitted by law, you must bring a claim within one year from the date on which you receive notice of the denial of your appeal.

Q4. Can I assign my rights under the Plan to another person or third party?

The assignment of benefits is governed by the Plan Component. However, if the Plan Component does not contain such a provision, the Plan will not permit the assignment of any rights under the Plan to another person or third party.

Even if an assignment is permitted under the Plan Component, the Plan Administrator or any delegated third-party, has the right to determine the validity of the assignment.

Q5. What is considered fraud or intentional misrepresentation?

Fraud or intentional misrepresentation occurs when you obtain benefits by fraudulently or intentionally misrepresenting a material fact to the Plan. If you fraudulently or intentionally misrepresent a fact, the Plan Administrator may take certain action, as permitted by law, at its sole discretion.

Q6. Is this document a contract between the Employer and the Employee?

No, this document is a Summary Plan Description and is intended to summarize general provisions of the Plan Document. This document does not constitute a contract of any type between the Employer and the Employee. Nothing in this document shall give an Employee any right of employment.

MISCELLANEOUS

Q1. What happens to my benefits if I take a leave of absence?

Depending on the leave policies and procedures adopted by your Employer, you may be able to continue certain benefits while on an approved leave of absence. If you are eligible to continue certain Plan Components, you may be required to complete certain forms or documents and pay towards the cost of coverage.

Q2. Is the Employer required to comply with FMLA?

Yes, the Employer is required to comply with the FMLA.

Q3. What happens if my leave is protected by the FMLA?

If your leave is protected under the FMLA, your benefits will continue while on leave as if you were an active Employee. Upon return, your benefits will be restored. Depending on the Plan Sponsor, you may be responsible for paying

contributions towards your coverage.

The Employer may offer the following options for payment of contributions:

- ***Paid Leave:*** contributions will be automatically deducted from payroll;
- ***Unpaid Leave:*** you may be required to submit payment to the Employer for any required contributions.

Q4. What happens if I experience a change in status while on FMLA leave?

If you experience a change in status, you may change your coverage election as if you were actively employed.

Q5. What happens if I don't return to work following my FMLA leave?

If you do not return to work following your FMLA leave, you may be entitled to COBRA continuation coverage, if applicable. You may also be required to reimburse the Employer for costs of coverage provided to you while you were on unpaid FMLA leave.

Q6. What happens if my leave is protected under USERRA?

If your leave is protected under USERRA, you may elect to continue coverage under the Plan for up to 24 months. To continue coverage, you must comply with the terms of the Plan, including election and payment of coverage. Moreover, upon return from leave protected under USERRA, your coverage will be reinstated.

DEFINITIONS

When used in the summary plan description with initial capital letters, the following words will have the meanings described below unless the content indicates other meanings are intended. If any defined term in this summary plan description conflicts with the same term contained in an insurance contract or other document, the other document shall govern.

ADULT CHILD
Means a Child(ren) that is over the age of 18.

BENEFICIARY
Means the individual designated by the Covered Employee to receive benefits provided under the applicable Life Insurance Accidental Death and Dismemberment, Voluntary Life, Voluntary Accidental Death and Dismemberment, or the Business Travel Accident Components of this Plan, as applicable.

CHILD(REN)
Unless differently defined under a Plan Component, "Child(ren)" means:

- Your (or your spouse's/domestic partner's) biological child, stepchild, legally adopted child (including any child lawfully placed for adoption with you by a court of competent jurisdiction);
- A foster child who has been placed with you by an authorized placement agency or by judgment, decree, or other court order of any court of competent jurisdiction;
- Your court-appointed legal ward under a Component Plan's limiting age provided he or she legally resides with you in a parent-child relationship and qualifies as your dependent for tax purposes.

CLAIM
Means a request for benefits made by an Eligible Employee under the terms of the Plan Component(s).

CODE
Means the Internal Revenue Code of 1986, as amended from time to time.

COMPONENT or PLAN COMPONENT
Means the benefit component available under the Plan, as identified in "Benefits, Q1."

COVERED EMPLOYEE
Means any Eligible Employee who is covered in one or more Plan Components.

COVERED DEPENDENT
Means an Eligible Dependent who is covered in one or more Plan Components.

DEPENDENT
Means the spouse of an Employee; the registered or unregistered Domestic Partner of an Employee; the registered civil union partner of an Employee; a Child of an Employee who has not attained age 26, as of the end of the taxable year. A Dependent may also include other individuals as identified in the applicable Component Document.

DOMESTIC PARTNER
Means a same sex or opposite sex couple that live together and share a relationship. The Employee should refer to the Plan Component's insurance contract or other document for specific requirements.

ELIGIBLE DEPENDENT
Means a Dependent that becomes covered under one or more of the Plan Component(s).

ELIGIBLE EMPLOYEE
Means an Employee that satisfies the requirements to be eligible to enroll in one or more Plan Component(s).

EMPLOYEE
Means, unless otherwise defined for a Plan Component, any person employed by the Employer. The term also may include a former employee that is a retiree. The term Employee excludes:

a. Any leased employee deemed to be an Employee of any Employer as provided in Code Sections 414(n) or (o); or
b. Any individual characterized as an independent contractor of the Employer.

EMPLOYER
Means any corporation, partnership, or other entity that employs employees. The Employer is the named Plan Administrator and the fiduciary of the Plan.

HEALTH CARE COMPONENT
Means any Plan Component that provides medical care, including Health Care, Dental, Vision, Flexible Spending Arrangement, a Health Reimbursement Arrangement, or an Employee Assistance Program.

MAJOR MEDICAL COMPONENT
A Plan Component that provides health care benefits, other than vision or dental benefits, to Covered Employees and their Eligible Dependents.

PLAN
Means the Ames Construction Health and Welfare Plan, as amended.

PLAN ADMINISTRATOR
Means the Employer, unless otherwise designated.

PLAN COMPONENT
Means the type of benefit provided under the terms of the Plan that is specifically structured under a separate policy, contract, or program as indicated in Section One.

PLAN DOCUMENT
Means the Welfare Benefit Plan Wrap Document and corresponding adoption agreement, and any separate policy, contract, or other document referred to in that document.

PLAN SPONSOR
Means the Employer or other entity listed in "Administrative Information, Q10."

PLAN YEAR
The Plan Year is October 1 through September 30 of the following calendar year.

ADMINISTRATIVE INFORMATION

Q1. Who has the authority to make determinations under the Plan?

The Plan Administrator has discretionary authority to interpret and make determinations under the Plan. The Plan Administrator may delegate its authority to third parties regarding claims administration, ministerial services, and other services, as necessary.

Q2. What are some of the duties of the Plan Administrator?

The Plan Administrator's duties include, but are not limited to, the following:

- Administer the Plan in accordance with its terms;
- Determine all questions of eligibility, status, and coverage under the Plan;
- Interpret the Plan, including ambiguities, inconsistencies, omissions, and disputed terms;
- Make factual findings;
- Decide disputes that may arise relative to a covered person's rights;
- Recommend procedures for filing a claim for benefits, review claim denials, and appeals relating to them, and uphold or reverse such denials;
- Keep and maintain Plan Documents and all other records pertaining to the Plan;
- Appoint and supervise a third-party administrator to pay claims;
- Perform all necessary reporting, as required by ERISA, if applicable;
- Establish and communicate procedures to determine an order's status as a QMCSO;
- Delegate to any person or entity powers, duties, and responsibilities, as necessary; and
- Perform functions necessary for the Plan's administration.

Q3. Can changes be made to the Plan?

Yes. While the Plan Sponsor intends to maintain the Plan indefinitely, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part. This includes amending benefits provided under Plan Components. If an amendment, suspension, or termination is enacted, the Plan Sponsor will provide notice, as required by law.

Q4. What happens if the Plan Administrator or its delegates makes a clerical error?

If the Plan Administrator or its delegated agent make a clerical error, the error will not invalidate coverage or cause coverage to be in force to remain in force. Rather, coverage effective dates will be determined solely in accordance with the provisions of the Plan, including any documents governing the Plan Components. Moreover, as permitted by law, the Plan Administrator will make an equitable adjustment as a result of an error or delay.

Q5. If the Plan receives a premium refund, will the reimbursement be paid to participants?

If the Plan has an insured Major Medical Component, the Plan may receive a refund of premium payments. For example, the Plan may receive a medical loss ratio rebate or an experience adjustment. If this occurs, the Employer will determine if the refund is a Plan asset. If so, the Plan Administrator will have discretion to pay the refund to participants as follows:

- Distribute a refund to Participants within 90 days of receipt,
- Use the refund to reduce Participants' portion of future premiums under the Plan; or
- Use the refund to enhance future benefits under the Plan.

If the Plan Administrator determines the refund is not a Plan asset, the use of the refund shall be decided by the Plan Sponsor and the participants will not have any right to reimbursement.

Q6. Who is responsible for the day-to-day operations of the Plan?

Your Employer is responsible for the Plan's day-to-day administration unless a Plan Administrator is appointed below.

- Appointed Plan Administrator

To assist in operating the Plan efficiently and accurately, your Employer may appoint additional persons or organizations to act on its behalf or to perform certain functions. The Plan Administrator may provide the claims administration through a third-party claims administrator.

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about the Plan. The Plan Administrator has the exclusive right to interpret the Plan's provisions. You may contact the Plan Administrator for any further information about the Plan.

Q7. Who is responsible for administering the Plan's claims?

The Claims Administrator is responsible for administering the Plan's claims. Refer to the chart in Appendix A for contact information.

Q8. Who is the Plan Sponsor?

The Plan Sponsor is Ames Construction, Inc.

Q9. Is the Plan subject to a collective bargaining agreement?

No

Q10. How can I obtain additional information about the Plan?

For additional information regarding the Plan, contact the Plan Administrator listed above, or refer to the Plan Documents. Copies of the Plan Documents are available free of charge from the Plan Administrator on request.

Q11. I received a medical child support order, what should I do?

If you receive a medical child support order, please send the order to the Plan Administrator. The Plan Administrator will then review the order to determine if it is a Qualified Medical Child Support Order (QMCSO). If it is determined the order is a QMCSO, the Plan will automatically change your benefit elections to provide coverage for the Child if the child is not already covered. Coverage for the Child will begin on the date specified in the order, or if none is specified, the date of the order, as permitted under a Plan Component.

Please Note: A Participant or Beneficiary of the Plan may obtain, without charge, a copy of the policy and/or procedures governing a QMCSO from the Plan Administrator.

Q12. When can the Plan Administrator retroactively terminate coverage provided under a Health Care Component?

A retroactive termination of coverage is referred to as a "rescission." The Plan Administrator may retroactively terminate your coverage or the coverage of your Dependent(s) if you commit fraud or intentional misrepresentation.

YOUR RIGHTS UNDER ERISA

Q1. Do I have any legal rights pursuant to ERISA?

Yes, the Plan is subject to ERISA.

Q2. What are my legal rights and protections under the Plan?

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants shall be entitled to the following.

Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and any collective bargaining agreements, and, if required by ERISA to be filed, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500) (if required by ERISA to be prepared) and updated SPD. The administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual Form 5500 (Summary of Annual Report), if required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Health Care Component Coverage

Continue Health Care Component coverage for yourself, spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing your COBRA continuation coverage rights. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your Health Care Component(s), if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your Health Care component or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. For more information about this statement or your rights under ERISA, including COBRA, ACA, HIPAA, and other laws affecting group health plans, or if you need assistance in obtaining documents from the Plan Administrator, 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 the EBSA website at 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.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. In addition, you may contact the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Participants and certain Dependents covered under this Plan can elect a temporary extension of coverage (called "COBRA continuation coverage") when coverage under the Plan would otherwise end because of a Qualifying Event. This notice is intended to inform Participants and Dependents, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA continuation coverage, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Qualified Beneficiaries.

Q1. What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of coverage under the Plan that must be offered to Qualified Beneficiaries. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Q2. Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be any of the following.

- Any individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being on that day either a Participant, a Participant's Spouse, or a Participant's Dependent Child.
- Any Child who is born to or placed for adoption with a Qualified Beneficiary who was an Employee during a period of COBRA continuation coverage.
- A Participant who retired on or before the date of substantial elimination of coverage under the Plan because of the Employer's bankruptcy proceeding under Title 11 of the U.S. Code. The Participant's Spouse, surviving Spouse, or Dependent Child is also a Qualified Beneficiary, if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse, or Dependent Child was a covered Dependent under the Plan.

An individual is not a Qualified Beneficiary if the individual's status as a Participant is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer earned income that did not constitute income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then the individual's Spouse or Dependent Child will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) have the opportunity to make an independent election to receive COBRA continuation coverage.

An individual covered under the Plan due to his or her status as an Employee's Domestic Partner is not provided with federal continuation coverage rights under COBRA. However, the Plan will provide such Domestic Partners with continuation coverage that mirrors the rights and obligations of continuation coverage of the spouse of an employee under COBRA.

Q3. What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage.

- The Participant's death.
- The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a Participant's employment.
- The divorce or legal separation of a Participant from the Participant's Spouse. If the Employee reduces or eliminates the Participant's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- A Participant's enrollment in any part of the Medicare program.
- A Dependent Child's ceasing to satisfy the Plan's requirements for a Dependent Child (for example, attainment of the maximum age for dependency under the Plan).
- An Employer's bankruptcy proceeding under Title 11 of the U.S. Code in respect to a Participant who is retired from employment at the time will also be a Qualifying Event for participants in this Plan.

If the Qualifying Event causes the Participant or the Participant's covered Spouse or a Dependent Child to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the Employer's bankruptcy, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the individuals losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met.

Taking FMLA leave does not constitute a Qualifying Event. A Qualifying Event will occur, however, if the Participant does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from that date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.).

Q4. What factors should be considered when determining to elect COBRA continuation coverage?

You may have the right to request special enrollment in another health Plan for which you are otherwise eligible (such as a Plan sponsored by your Spouse's Employer) within 30 days after Plan coverage ends because of a Qualifying Event listed above. You may also have the same special right at the end of COBRA continuation coverage if you elect COBRA continuation coverage for the maximum time available to you.

Q5. What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

Q6. What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of 1) the date the Qualified Beneficiary would lose coverage because of the Qualifying Event, or 2) the date notice is provided to the Qualified Beneficiary of the Qualified Beneficiary's right to elect COBRA continuation coverage.

Q7. Is a Participant or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a qualifying event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is

- the end of employment or a reduction of hours of employment,
- the participant's death,
- the commencement of the Employer's bankruptcy proceeding, or
- the Participant's entitlement to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Participant and Spouse, or a Dependent Child's losing eligibility for coverage as a Dependent Child), the Participant or the other Qualified Beneficiary must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if a written notice is not provided to the Plan Administrator or its designee during the 60 day notice period, any Qualified Beneficiary who loses coverage will not have the option to elect continuation coverage. The notice must be sent to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail, fax, or hand deliver your notice to the person, department, or firm listed below, at the following address.

Ames Construction, Inc.
Attn: HR Department
2500 County Road 42 West
Burnsville, MN 55337

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must include

- the Plan's name,
- the name and address of the Participant and any other Qualified Beneficiaries, and
- the Qualifying Event and the date it happened.

If the Qualifying Event is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement.

Be aware that there are other notice requirements in other contexts. For example, in order to qualify for a disability extension of COBRA continuation coverage.

Once the Plan Administrator or its designee receives timely 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. Participants may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage would otherwise have been lost. If the Qualified Beneficiary does not elect COBRA continuation coverage within the 60 day election period described above, the right to elect COBRA continuation coverage will be lost.

Q8. Will a waiver made before the end of the election period end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. The waiver's revocation is an election of COBRA continuation coverage. If a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Q9. Is COBRA continuation coverage available if a Qualified Beneficiary has Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are entitled to Medicare benefits on or before the date on which COBRA continuation coverage is elected. But a Qualified Beneficiary's COBRA continuation coverage will terminate automatically if, after electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to Medicare or becomes covered under another health Plan.

Q10. When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

A Qualified Beneficiary may waive COBRA continuation coverage during the election period. Except for an interruption of coverage in connection with a waiver, a Qualified Beneficiary's COBRA continuation coverage must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates.

- The last day of the applicable maximum coverage period.
- The first day for which timely payment is not made to the Plan with respect to the Qualified Beneficiary.
- The date upon which the Employer ceases to provide any health Plan (including a successor Plan) to any Employee.
- The date, after the date of the election, that the Qualified Beneficiary first becomes covered under a health Plan.
- The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).
- The later of the following two dates if the Qualified Beneficiary is entitled to a disability extension.
    1. The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.
    2. The earlier of 1) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled, or 2) 29 months after the date of the Qualifying Event.

The Plan can terminate for cause a Qualified Beneficiary's coverage on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries (for example, for submitting a fraudulent claim).

If the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, and an individual who is not a Qualified Beneficiary receives coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

Q11. What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the Qualifying Event type and the Qualified Beneficiary's status, as shown below.

- If a Qualifying Event is based on a Termination of Employment or reduction of hours of employment, the maximum coverage period ends
  - 18 months after the Qualifying Event if there is not a disability extension, and
  - 29 months after the Qualifying Event if there is a disability extension.
- If a Participant enrolls in Medicare before experiencing a Qualifying Event that is a Termination of Employment or a reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the Participant ends on the later of
  - 36 months after the date the Participant becomes enrolled in Medicare (this extension does not apply to the covered Employee); or
  - 18 months (29 months, if there is a disability extension) after the date of the Participant's Termination of Employment or reduction of hours of employment.
- If a Qualified Beneficiary is a Child born to or placed for adoption with a Participant during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the Child was born or placed for adoption.
- For any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.
- For a Qualifying Event due to bankruptcy, there will be a maximum coverage period for a Qualified Beneficiary.

For a Qualifying Event due to bankruptcy, the maximum coverage period for a Qualified Beneficiary who is the Participant ends on the date of the retiree's death. For a Qualified Beneficiary who is the Participant's covered Spouse, surviving Spouse, or Dependent Child, the maximum coverage period ends on the earlier of 1) the Qualified Beneficiary's death, or 2) 36 months after the retiree's death.

Q12. Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18 month or 29 month maximum coverage period is followed by a second Qualifying Event that gives rise to a 36 month maximum coverage period within the original 18 or 29 month period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the maximum coverage period for COBRA continuation coverage be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures described above.

Q13. How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if a Qualified Beneficiary 1) has a Qualifying Event because of a termination or a reduction of hours of the Participant's employment, and 2) is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first

60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also notify the Plan Administrator of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18 month maximum coverage. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures described above.

Q14. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

Q15. What is considered timely when paying for COBRA continuation coverage?

Payment is made timely if made no later than 30 days after the first day of the coverage period.

The Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to those providing COBRA continuation coverage.

If you make a timely payment and the payment is less than the amount the Plan requires, the Plan Administrator may

consider the amount timely if
1) the amount owed is insignificant, and 2) you pay the amount owed within a reasonable period. A reasonable period is 30 days and an insignificant amount is considered $50 or 10% of the required amount. Please see the Plan Document for additional information.

If You Have Questions
If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under ERISA, including COBRA, HIPAA, 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). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Administrator Informed of Address Changes
To protect your family's rights, you should keep the Plan Administrator informed of any changes in your family members' addresses. You should also keep a copy, for your records, of any notices that you send to the Plan Administrator or its designee

PRIVACY RIGHTS UNDER HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes how your Protected Health Information ("PHI") may be used or disclosed under the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") means individually identifiable health information held by, or on behalf of, the Plan.

Uses and Disclosures of Your Information
The Ames Construction Health and Welfare Plan may use or disclose your PHI for the purposes of routine treatment, payment, or health care operations related to the Plan. For example, the Plan may use your PHI for management activities related to the Plan—including auditing, fraud and abuse detection, and customer service. The Plan also may use or disclose your PHI in order to pay your Claims for benefits. For example, the Plan may use your information to make eligibility determinations and for billing and Claims management purposes. Note that the Genetic Information Nondiscrimination ACT (GINA) prohibits using PHI that is genetic information for underwriting purposes. In addition, the Plan may disclose your PHI to the Plan Administrator so that the Plan Administrator can perform administrative functions on behalf of the Plan, such as facilitating Claims or appeals.

The Plan also may use or disclose your PHI where required or permitted by law. Federal law, under HIPAA generally permits health Plans to use or disclose PHI

- when required by law;
- for public health activities;
- to report Child or domestic abuse;
- for governmental oversight activities;
- pursuant to judicial or administrative proceedings;
- for certain law enforcement purposes;
- for a coroner, medical examiner, or funeral director in order to obtain information about a deceased individual;
- for organ, eye, or tissue donation purposes;
- for certain government-approved research activities;
- to avert a serious threat to an individual's or the public's health or safety;
- for certain government functions, such as related to military service or national security;
- to comply with workers' compensation laws;
- to a family member or close friend that you have identified and who is directly involved in your care or payment for your care; or
- to notify a family member of other individual involved in your care of your location, general condition, or death or to a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notifications.

For any other uses and disclosures of your PHI, the Plan will obtain your written authorization. The Plan will obtain your written authorization to use or disclose PHI for marketing purposes where the Plan receives financial remuneration, for the sale of PHI, or with respect to psychotherapy notes, except for limited health care operations purposes. You may revoke this authorization in writing at any time, provided the Plan has not yet acted while relying on your authorization.

Stricter State Privacy Laws – Under the HIPAA privacy and security rules, the Plan is required to comply with state laws, if any, that also are applicable and are not contrary to HIPAA (for example, where state laws may be stricter). The Plan maintains a policy to ensure compliance with these laws.

Your Rights With Respect To Your Health Information
You have several rights with respect to your PHI, which are described below. Please call the Privacy Officer listed below if you have questions about your rights.

- You have the right to request restrictions on how your PHI may be used or disclosed. The Plan generally is not required to agree to your requested restriction, except in limited circumstances.
- You have the right to receive your PHI confidentially, such as at a location other than your home, if you state in writing that disclosing the information through normal means could endanger you.
- You have the right to inspect and copy your PHI that is maintained by the Plan in a designated record set or to request an electronic copy. The Plan may charge a reasonable, cost-based fee for such copies.
- You have the right to request an amendment to your PHI that the Plan maintains in a designated record set. The Plan may deny your request for an amendment if it believes your information is accurate and complete, or if the information was created by a party other than the Plan.
- You have a right to request an accounting of disclosures that the Plan has made of your PHI during the six years before your request, except for disclosures that you have authorized or for disclosures related to routine treatment, payment, or health care operations of the Plan.
- You have a right to request a paper copy of this notice, even if you have agreed to receive this notice electronically.

Our Duties With Respect to Your Individually Identifiable Health Information
The Plan is required by law to maintain the privacy of your PHI and to provide you with a notice of its legal duties and privacy practices with respect to your PHI.

Questions?
If you have questions or would like more information about the Plan's privacy policies, you may contact the Privacy Officer. The Privacy Officer is responsible for developing and implementing the Plan's privacy policies and procedures.

If you believe your privacy rights have been violated, you may file a complaint with the Plan or the Secretary of the U.S. Department of Health and Human Services. You cannot be retaliated against for filing such a complaint.

OTHER LEGAL NOTICES

Q1. Do I have any other legal rights and protections under the Plan?

Yes, the Plan is required to comply with other federal regulations, which guarantee certain legal rights and protections, as follows:

Your Rights Under the Patient Protection and Affordable Care Act
The Patient Protection and Affordable Care Act (PPACA or ACA) provides certain consumer protections, including the elimination of annual and lifetime limits on benefits, the provision of preventive services without cost-sharing, the limitation of out-of-pocket annual costs, the coverage of essential health benefits, the elimination of waiting periods of more than 90 days for coverage to begin, the elimination of pre-existing conditions, and the guarantee of issue and renewal of coverage. As applicable, these provisions are contained within the Major Medical Component documents.

Your Rights Under the Family and Medical Leave Act
The Family and Medical Leave Act (FMLA) provides that Health Care Component(s) must be maintained during any period of unpaid leave covered by the FMLA under the same conditions as if you continued to work. Moreover, the FMLA requires that you be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA. If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse the Employer for its share of Health Care Component(s) premiums or contributions paid on your behalf during your FMLA leave.

Your Rights Under the Genetic Information Nondiscrimination Act of 2008
The Genetic Information Nondiscrimination Act of 2008 (GINA) provides that your Employer may not discriminate against you on the basis of genetic information, including adjusting premiums and contribution amounts.

Your Rights Under the Health Insurance Portability and Accountability Act (Special Enrollment)
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides certain special enrollment rights if you decline coverage in the Major Medical Component(s) for yourself or your Dependents because of other coverage. If you or your Dependents lose eligibility for that other coverage or if the employer stops contributing toward your or your

Dependent(s)' other coverage, you may be able to enroll yourself and your Dependent in the Major Medical Component(s). Generally, you must request enrollment within 30 days after your or your Dependent(s)' other coverage ends or after the employer stops contributing toward the other coverage.

If the other coverage is Medicaid or the Children's Health Insurance Program (CHIP), you must request enrollment within 60 days after your or your Dependent(s) Medicaid or CHIP coverage ends. Finally, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Your Rights Under the Health Insurance Portability and Accountability Act (Health Factors)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits the Major Medical Component from discriminating against you or your Dependents based on a health factor. Health factors include your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. Compliance with this provision is not determinative of compliance with any other federal or state laws, including COBRA or the American with Disabilities Act.

Your Rights Under the Mental Health Parity and Addiction Equity Act of 2008

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) provides that if any Major Medical Component option under the Plan

(i) provides for both medical and surgical benefits and mental health or substance use disorder benefits, and (ii) is not subject to increased cost exemption (within the meaning of the MHPAEA), the following conditions apply:

- The Major Medical Component may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits.
- The Major Medical Component may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the predominant limitations applied to substantially all of the medical and surgical benefits in any classification.
- The criteria for medical necessity determinations made under any health insurance option with respect to mental health or substance use disorder benefits will be made available by the Plan Administrator (in accordance with the MHPAEA) to any current or potential participant upon request.
- The reason for any denial under the Plan for reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant will, on request or as otherwise required under the MHPAEA, be made available by the Plan Administrator to the participant in accordance with the claims procedures applicable to the group medical coverage feature.
- The Plan will be operated and constructed in all respects in compliance with the MHPAEA.

"Mental health benefits" and "substance use disorder benefits" are defined in the Major Medical Component applicable to the medical insurance option, pursuant to applicable state and federal law, and consistent with generally recognized standards of current medical practice.

Your Rights under Michelle's Law

Michelle's Law provides that Major Medical Component(s) of the Plan that require a certification of student status for any period of coverage of an Eligible Dependent will comply with Public Law No. 110-381 (2008), as amended from time to time. Eligibility for such coverage for an Eligible Dependent who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence will be extended if the leave normally would cause the Eligible Dependent to lose eligibility for coverage under any Major Medical Component's coverage due to loss of student status. This eligibility extension shall last up to one year beginning on the first day of the medically necessary leave of absence or the date the coverage would otherwise terminate due to loss of student status, whichever is earlier.

Your Rights Under Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (NMHPA) provides that the Major Medical Component(s) of the Plan 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 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, the Major Medical Component(s), under federal law, require that the 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).

Your Rights Under USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA) provides for continuation of Health Care Component coverage if you are called for active-duty military service. The maximum length of extended coverage under USERRA is the lesser of

- 24 months beginning on the date that the military leave begins or

- a period beginning on the day that the leave began and ending on the day after your reemployment application deadline.

If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional 2% administration fee. If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the U.S. Department of Veterans Affairs) incurred as a result of the military service.

Your Rights Under Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires that the Major Medical Component(s) that provide medical and surgical benefits with respect to a mastectomy provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema.

These services must be provided in a manner determined in consultation with the attending Physician and the patient. This coverage may be subject to annual deductibles, copays and coinsurance provisions applicable to other such medical and surgical benefits provided under the applicable medical option. Please refer to the Major Medical Component(s)'s summary of benefits coverage for additional information. If you have other questions, please contact the Plan Administrator.

Q2. Is there anything else I should know?

Effective 10/1/2025, Domestic Partners are ineligible to participate in the plan. Any Domestic Partners enrolled prior to 10/1/2025 are hereby grandfathered into coverage. For those with an enrolled Domestic Partner or civil union partner in the Plan, you must be aware of the following:

- ***Tax***: Under current federal income tax laws, the value of providing medical benefits to a Domestic Partner or civil union partner and the partner's Eligible Dependent Children is considered taxable to you—unless they are considered your Dependents for purposes of federal income taxes. This means you will pay federal, state, and local income taxes, as well as employment taxes, on the full value of the coverage provided to your Domestic Partner or civil union partner and the partner's Dependents. This type of taxable income is known as imputed income, and your Employer will report it on your Form W-2 at the end of each year.
  It's important for you to understand the tax implications of covering a Domestic Partner or a civil union partner and the partner's Eligible Dependent Children. Please consult a tax advisor to determine the full tax and financial effect of electing this coverage.
- ***COBRA:*** While an individual covered under the Plan due to his or her status as an Employee's Domestic Partner is not provided with federal continuation coverage rights under COBRA, the Plan, at the Plan Sponsor's discretion, will provide such Domestic Partners with continuation coverage that mirrors the rights and obligations of continuation coverage of the spouse of an employee under COBRA.

APPENDIX A
Ames Construction Health and Welfare Plan for Non-Union Employees

Plan Components and Claims Administrators

Plan Components are incorporated by reference herein. All subsequent updates to such Benefit Documents will supersede any earlier versions for the periods defined in the updated materials.

Insured Plan Components	Policy/Group No.	Type of Benefit	Claims Administrator	
The Prudential Insurance Company of America (Prudential) 751 Broad Street Newark, NJ 07102	72649	Basic Life Basic AD&D Voluntary Life Voluntary AD&D	The Prudential Insurance Company of America Prudential Group Life Claim Division P.O. Box 8517 Philadelphia, PA 19176	1-800-524-0542 https://www.prudential.com/personal/life-insurance/file-a-life-insurance-claim
		Disability	The Prudential Insurance Company of America ("Prudential") 751 Broad Street Newark, New Jersey 07102	877-367-7781 www.prudential.com/mybenefits
		Voluntary Worksite Benefits	The Prudential Insurance Company of America c/o Accenture Insurance Services as Third-Party Administrator PO Box 71330 Philadelphia, PA 19176-1330	844-455-1002 www.prudential.com/mybenefits
Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670	30078492	Vision	VSP Attn: Claims Department PO Box 385018 Birmingham, AL 35238- 5018	800-877-7195 www.vsp.com/faqs/claims-reimbursement/submit-a-claim

Self-insured Plan Components	Contract No.	Type of Benefit	Claims Administrator	
Blue Cross Blue Shield of Minnesota 3535 Blue Cross Road Eagan, MN 55122	295109	Medical - PPO	BCBS of MN Attn: Claims Department PO Box 982805 El Paso, TX 79998-2805	800-382-2000 www.bluecrossmn.com/members/blue-cross-claims
CVS/Caremark One CVS Drive Woonsocket, RI 02895	-	Prescription	CVS/Caremark Attn: Claims Department PO Box 52196 Phoenix, AZ 85072-2196	877-264-2955 www.caremark.com
Delta Dental of Minnesota 500 South Washington Ave Minneapolis, MN 55414	5934	Dental - PPO	Delta Dental MN Attn: Claims Department PO Box 9120 Farmington Hills, MN 48333-9120	800-448-3815 www.deltadentalmn.org

Plan Components are incorporated by reference herein. All subsequent updates to such Benefit Documents will supersede any earlier versions for the periods defined in the updated materials.

Non-ERISA Benefits

In addition to the above Component Plans, eligible employees are offered non-ERISA welfare benefits. Such non-ERISA benefits are not governed by ERISA or the "Statement of ERISA Rights" section of this SPD, and include the following benefit plan(s):

- Self-insured Health Savings Account administered by Empower
- Employee Assistance Program services administered by Lyra Health

APPENDIX B
Ames Construction Health and Welfare Plan for Non-Union Employees

Eligibility and Participation Requirements

An Employee who is determined to be benefit-eligible as of his or her start date will be offered coverage as of the Enrollment Date specified below.

Eligible Employee Class	Benefit	Eligibility Date	Termination Date
Full-Time Non-Union Employees working 40 hours per week	All Benefits listed on Appendix A	First day of the month following date of hire Exception: Short-term Disability begins 90 days after hire	The final day of the month in which the employee ceases to satisfy the eligibility requirements (unless otherwise noted under each Component Plan)

Change in Status from Non-Union to Union Employee

Non-Union employees who join the Union may remain on the Ames Construction, Inc. Employee Health and Welfare Plan for up to 150 days following the status change.

Dependent Eligibility

Unless specified otherwise under the applicable Plan Component's benefit documents, coverage for dependents, if elected, begins on the date the Employee's coverage begins (provided the Employee timely enrolls them in coverage). Mid-Plan Year elections for newly acquired Dependents may also be permitted under certain circumstances.

Dependent Definitions

For purposes of eligibility and participation in this Plan, Dependent definitions shall have the same meaning set forth in each applicable Plan Component's benefit documents which are incorporated by reference herein. Unless otherwise defined in the Plan Component's benefit documents, your eligible dependents include:

- Your lawful same - or opposite - sex spouse under applicable law (including your common-law spouse), unless legally separated by court decree; or Your civil union partner
- Your child(ren) under age 26* (regardless of financial dependency, residency with you, marital status, or student status), or if older, your unmarried child who is principally supported by you and who you can certify (on a periodic basis) is not capable of self-support due to a physical or mental disability that either began while the child was covered under the Plan or occurred prior to attaining age 26. For purposes of the Plan, a child includes:
    - Your (or your spouse's) biological child, legally adopted child (including any child lawfully placed for adoption with you by a court of competent jurisdiction);
    - A foster child who has been placed with you by an authorized placement agency or by judgment, decree, or other court order of any court of competent jurisdiction;
    - Your court-appointed legal ward under a Component Plan's limiting age provided he or she legally resides with you in a parent-child relationship and qualifies as your dependent for tax purposes.

An eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order or a National Medical Support Notice, including a judgment, decree, or order issued by a court of competent jurisdiction, or an order issued through an administrative process that has the force and effect of law under applicable state law.

*Under age 25 for Voluntary Workplace Benefits (Accident Insurance, Hospital Indemnity, Critical Illness).

Rehire Rule

Unless otherwise specified to the contrary in a Plan Component's Benefit Documents, an Employee who is rehired within 13-consecutive weeks after date of termination will be eligible to enroll in Plan benefits on his or date of rehire. Otherwise, a terminated employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and participation requirements for his or her employment class.

Pre-Age 65 Retiree Eligibility

A retiree who is determined to be eligible for retiree coverage under the Plan as of his or her retirement date will be offered the following Plan benefits:

Class Description	Applicable Plan Component	Age & Service Requirements	Enrollment Date
Pre-Age 65 Non-Union Retirees	Medical/Prescription and Dental (only eligible for the Traditional PPO Plan)	Between the ages of 62 and 65 with at least 30 years of service with Ames.	First day of the next month following date of retirement

You and your lawful spouse are eligible to continue to participate in the Traditional PPO Medical/Prescription and Dental Plans if you are a retiree of the participating employer and you are age 62 or older and have completed 30 years of continuous service with the participating employer before retirement. Once a qualified retiree or his or her spouse becomes eligible for Medicare or reaches age 65, whichever comes first, then the qualified retiree's or spouse's coverage under this Plan will terminate at the end of the month following the Medicare eligibility date. If the qualified retiree's spouse has not already become eligible for Medicare or reaches age 65, their coverage will end at the end of the month that the qualified retiree's coverage ends.

APPENDIX C
Ames Construction Health and Welfare Plan for Non-Union Employees

ACA Employee Eligibility Requirements

If the Employer cannot determine your full-time Employee status at the time of hire, the Employer will determine your full-time Employee status by using the following methods:

Look-back Measurement Method

The Employer will determine your status as an ACA full-time Employee during a future period (the stability period) based on your hours of service during a prior period (the measurement period).

Your Employer has selected specified Look-Back Measurement periods summarized in the chart below. The "initial" periods apply if you were recently hired. The "standard" periods apply if you are a continuing Employee. The measurement period is the period of time used to calculate your status. The stability period is the period following the end of the measurement period used to offer Major Medical Component coverage. The administrative period is the period used by the Employer to determine your status, provide information or enrollment materials, and perform other administrative functions.

	Initial (Newly Hired Employee Only)	**Standard** (Continuing Employee)
Measurement	12 Months	August 1 to July 31 of the following year
Administrative	1 Month	August 1 to September 30 of the same year
Stability	12 Months	October 1 to September 30 of the following year

Employee Classifications

- Variable Hour
- Part-Time
- Seasonal

Benefits Offered

Major Medical and Prescription

Break in Service Rule

If you are terminated from employment and are later rehired, you are considered a new Employee if you have not been credited with at least one hour of service within 13 or more consecutive weeks.

For additional information regarding your full-time Employee status, please contact your Plan Administrator.

SUMMARY OF MATERIAL MODIFICATIONS 2026

To: **Participants**

From: **Human Resources**

Re: **Amendment to the Ames Construction Health and Welfare**

Plan Effective Date: October 1, 2026

This Summary of Material Modifications (SMM) describes changes to the Ames Construction Health and Welfare Plan (Plan) and supplements or modifies the information presented in your Summary Plan Description (SPD) with respect to the Plan. You should keep this SMM with the Plan's SPD and associated benefits documents provided to you upon enrollment in each benefit plan.

Changes to the Plan Provisions

Notwithstanding any provision contained in the Plan to the contrary, the Plan is amended as follows.

APPENDIX B
Ames Construction, Inc. Employee Health and Welfare Plan for Non-Union Employees

Eligibility and Participation Requirements

Prior to 10/1/26: Eligible Employee Class included employees working at least 30 hours per week. Eligibility for short-term disability started the first of the month following date of hire.

Eligible Employee Class	Benefit	Eligibility Date	Termination Date
Full-Time Non-Union Employees working at least 30 hours per week	All Benefits listed on Appendix A	First day of the month following date of hire	The date of end of the month (as applicable under each Component Plan) in which the employees ceases to satisfy the eligibility requirements.

Prior to 10/1/26: Retirees were eligible for Medical/Prescription, Dental, and Vision. Retirees enrolled prior to 10/1/2026 are grandfathered into Vision coverage.

Pre-Age 65 Retiree Eligibility

A retiree who is determined to be eligible for retiree coverage under the Plan as of his or her retirement date will be offered the following Plan benefits:

Class Description	Applicable Plan Component	Age & Service Requirements	Enrollment Date
Pre-Age 65 Non-Union Retirees	Medical/Prescription, Dental, Vision (only eligible for the Traditional PPO Plan)	Between the ages of 62 and 65 with at least 30 years of service with Ames Construction, Inc.	First day of the next month following date of retirement

APPENDIX C
Ames Construction Health and Welfare Plan for Non-Union Employees

Prior to 10/1/26: Benefits offered to ACA eligible employees included Major Medical/Prescription, Dental, and Vision.

Benefits Offered

Major Medical/Prescription, Dental, and Vision

SUMMARY OF MATERIAL MODIFICATIONS 2025

To: Participants

From: Human Resources

Re: Amendment to the Ames Construction Health and Welfare

Plan Effective Date: October 1, 2025

This Summary of Material Modifications (SMM) describes changes to the Ames Construction Health and Welfare Plan (Plan) and supplements or modifies the information presented in your Summary Plan Description (SPD) with respect to the Plan. You should keep this SMM with the Plan's SPD and associated benefits documents provided to you upon enrollment in each benefit plan.

Changes to the Plan Provisions

Notwithstanding any provision contained in the Plan to the contrary, the Plan is amended as follows.

1. **Revised Eligibility and Participation Requirements for Benefit-Eligible Dependents:** As of the Effective Date, Ames Construction hereby amends the eligibility and participation requirements for Plan benefits. The updated revised Appendix B ("Eligibility and Participation Requirements") shall supersede all prior versions of the same Appendix. Attached is the version previous to 10/1/25.
    a. Benefit Plan changes include:
        i. Removal of Domestic Partner eligibility, except for enrollees prior to 10/1/2025 who are hereby grandfathered into the plan.
        ii. Updated Voluntary Workplace Benefit dependent eligibility to age 25, in accordance with legislation.
2. **Changes to Insurance Policy Issuers and Contract Administrators.** As of the Effective Date, Ames Construction has amended the Plan to modify the Plan's appointed group insurance policy issuers and/or contract administrators. The updated revised Appendix A (Plan Components and Claims Administrators) shall supersede all prior versions of the same Appendix A. Attached is the addition on 10/1/25.
    - Benefit Plan changes include:
        - Insured Plan Components for Basic Life, Basic AD&D, Voluntary Life, Voluntary A&D, Disability, and Voluntary Worksite Benefits under Metropolitan Life Insurance Company (MetLife) transferred to The Prudential Insurance Company of America (Prudential);
        - Removal of Dependent Care Flexible Spending Account;
        - Health Savings Account (HSA) administration transferred from Optum to Empower.

APPENDIX A
Ames Construction, Inc. Employee Health and Welfare Plan for Non-Union Employees Plan

Plan Components and Claims Administrators

Prior to 10/1/25: Insured Plan Components for Basic Life, Basic AD&D, Voluntary Life, Voluntary A&D, Disability, and Voluntary Worksite Benefits were under Metropolitan Life Insurance Company (MetLife).

Non-ERISA Benefits

Prior to 10/1/25: self-insured Health Savings Account and Dependent Care Flexible Spending Account administration by Optum.

APPENDIX B
Ames Construction, Inc. Employee Health and Welfare Plan for Non-Union Employees

Dependent Definitions

Prior to 10/1/2025: Dependent Definitions included:

- Your domestic partner who meets the eligibility requirements adopted by Ames Construction as an adult of the same or opposite sex with whom you have an emotional, physical, and financial relationship, similar to that of a spouse; or,
- Your domestic partner with whom you have lawfully registered into a domestic partnership in a state or municipality that provides for such registration
- Children under age 26 for all benefits

SUMMARY OF MATERIAL MODIFICATIONS 2024

To: Participants

From: Human Resources

Re: Amendment to the Ames Construction Health and Welfare

Plan Effective Date: October 1, 2024

This Summary of Material Modifications (SMM) describes changes to the Ames Construction Health and Welfare Plan (Plan) and supplements or modifies the information presented in your Summary Plan Description (SPD) with respect to the Plan. You should keep this SMM with the Plan's SPD and associated benefits documents provided to you upon enrollment in each benefit plan.

Changes to the Plan Provisions

Notwithstanding any provision contained in the Plan to the contrary, the Plan is amended as follows.

1. **Revised Eligibility and Participation Requirements for Benefit-Eligible Employees**. As of the Effective Date, Ames Construction hereby amends the eligibility and participation requirements for Plan benefits. The updated revised Appendix B ("Eligibility and Participation Requirements") shall supersede all prior versions of the same Appendix. Attached is the version previous to 10/1/24.
   - Benefit Plan changes include:
     - Non-union to Union Status Changes: Non-Union employees who join the Union may remain on the Ames Construction, Inc. Employee Health and Welfare Plan for up to 150 days following the status change.

APPENDIX B
Ames Construction, Inc. Employee Health and Welfare Plan for Non-Union Employees

Prior to 10/1/2024: Non-Union to Union status changes were eligible for 90 days:

Change in Status from Non-Union to Union Employee

Non-Union employees who join the Union may remain on the Ames Construction, Inc. Employee Health and Welfare Plan for up to 90 days following the status change.

SUMMARY OF MATERIAL MODIFICATIONS 2023

To: Participants

From: Human Resources

Re: Amendment to the Ames Construction Health and Welfare

Plan Effective Date: October 1, 2023

This Summary of Material Modifications (SMM) describes changes to the Ames Construction Health and Welfare Plan (Plan) and supplements or modifies the information presented in your Summary Plan Description (SPD) with respect to the Plan. You should keep this SMM with the Plan's SPD and associated benefits documents provided to you upon enrollment in each benefit plan.

Changes to the Plan Provisions

Notwithstanding any provision contained in the Plan to the contrary, the Plan is amended as follows.

1. **Changes to Insurance Policy Issuers and Contract Administrators.** As of the Effective Date above, Ames Construction has amended the Plan to modify the Plan's appointed group insurance policy issuers and/or contract administrators. The updated revised Appendix A (Plan Components and Claims Administrators) shall supersede all prior versions of the same Appendix A. Attached is the addition on 10/1/23.
   - Benefit Plan changes include:
     - Adding Health Savings Account and Dependent Care Flexible Spending Account with Optum;
     - Adding Employee Assistance Program with Lyra Health

2. **Revised Eligibility and Participation Requirements for Benefit-Eligible Employees.** As of the Effective Date, Ames Construction hereby amends the eligibility and participation requirements for Plan benefits. The updated revised Appendix B ("Eligibility and Participation Requirements") shall supersede all prior versions of the same Appendix. Attached is the version previous to 10/1/23.
   - Benefit Plan changes include:
     - Retiree eligibility: eligible for only the Traditional PPO medical plan

APPENDIX A
Ames Construction, Inc. Employee Health and Welfare Plan for Non-Union Employees Plan

Additions to the plan effective 10/1/2023:
Non-ERISA Benefits. In addition to the above Component Plans, eligible employees are offered non-ERISA welfare benefits. Such non-ERISA benefits are not governed by ERISA or the "Statement of ERISA Rights" section of this SPD, and include the following benefit plan(s):

- Self-insured Health Savings Account and Dependent Care Flexible Spending Account administration by Optum
- Employee Assistance Program services administered by Lyra Health

APPENDIX B
Ames Construction, Inc. Employee Health and Welfare Plan for Non-Union Employees

Prior to 10/1/2023: Retirees were only eligible for the Basic Plan:

Pre-Age 65 Retiree Eligibility
A retiree who is determined to be eligible for retiree coverage under the Plan as of his or her retirement date will be offered the following Plan benefits:

Class Description	Applicable Plan Component	Age & Service Requirements	Enrollment Date
Pre-Age 65 Non-Union Retirees	Medical, Dental, Vision Only Eligible for Basic Plan	Between the ages of 62 and 65 with at least 30 years of service with Ames Construction, Inc.	First day of the next month following date of retirement

You and your lawful spouse are eligible to continue to participate in the Basic Plan if you are a retiree of the participating employer and you are age 62 or older and have completed 30 years of continuous service with the participating employer before retirement. Once a qualified retiree or his or her spouse becomes eligible for Medicare or reaches age 65, whichever comes first, then the qualified retiree's or spouse's coverage under this Plan will terminate on the Medicare eligibility date. If the qualified retiree's spouse has not already become eligible for Medicare or reaches age 65, their coverage will end at the end of the month that the qualified retiree's coverage ends.

All other Plan provisions remain unchanged so long as they are consistent with these material modifications.

For additional information regarding the Plan or to request a copy of the Plan's SPD, contact:
Ames Construction
2500 County Road 42 West, Burnsville, MN 55337
Attn: Human Resources
amesbenefits@amesco.com

Plan Information:
Plan Name: Ames Construction Health and Welfare Plan
Plan Number: 505
Plan Year: October 1 through September 30 of the following calendar year