KE&G
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1972 2022
100% Employee Owned

2022 KE&G Construction Benefits Guide

Welcome to your 2022 Benefits Plan Year. KE&G Construction is proud to offer a range of employee benefit plans to help protect you in the case of illness or injury. This Benefits Information Guide is a comprehensive tool designed to familiarize you with the plans and programs you and your family can enroll in for the plan year. If you have any questions regarding your benefits, please contact Human Resources.

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 2 months, Federal law gives you more choices about your prescription drug coverage. Please see page 24 for more details.

Eligibility & Enrollment

Your Benefits Package

KE&G Construction is pleased to provide you and your family with a comprehensive benefits package. We believe that our benefits offer you both choice and opportunity. They remain competitive and affordable in the marketplace. Best of all—they provide you with a great benefits package value. This Benefits Guide provides general information to get you started; however, more detailed information is available within the contracts between KE&G Construction and the insurance providers. These legal documents always govern and determine your exact benefits. Information within this Guide is subject to change throughout the plan year.

Who can Enroll?

If you are an employee regularly working a minimum of 30 hours per week, you are eligible to participate in the benefits program. Eligible employees may also choose to enroll family members, including a legal spouse) and/or eligible children who are under the age of 26. Dependent children covered under Supplemental Life & AD&D must be unmarried and financially dependent on the employee. For eligibility qualifications for spouse and dependent children, please refer to each carrier's Certificate of Coverage.

When Does Coverage Begin?

Regular, full-time employees: You are eligible to enroll on your date of hire, but your coverage will not be effective until first of the month following 60 days. Your enrollment choices remain in effect through the end of the benefits plan year, (October 1, 2022 – September 30, 2023)

Paying for Benefits

The following pages outline your benefit options and your cost to participate. The Section 125 Plan provides tax savings by reducing employee premiums from gross salary prior to calculation of Federal and State income taxes and Social Security taxes. By taking advantage of this program via payroll deduction throughout the year, you cannot claim these same expenses on your income tax return.

TIP

If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status during the plan year. Please review details on IRS qualified change in status events for more information.

What if My Needs Change During the Year?

You are permitted to make changes to your benefits outside of the open enrollment period if you have a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the qualified event. Change in status examples include:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Death of a spouse or child
- You or your spouse's loss or gain of coverage through our organization or another employer
- An employee (1) is expected to average at least 30 hours of service per week, (2) has a change in status where he/she will reasonably be expected to average less than 30 hours of service per week (even if he/she remains eligible to be enrolled in the plan); and (3) intends to enroll in another plan that provides Minimum Essential Coverage (no later than the first day of the second month following the month of revocation of coverage)
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace or Federal Exchange and it is effective no later than the day immediately following the revocation of your employer sponsored coverage

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of qualified status changes, please refer to the "Legal Information Regarding Your Plans" contents on page 25.

Do I Have to Enroll?

Although the federal penalty requiring individuals to maintain health coverage has been reduced to $0, some states have their own state-specific individual mandates. Arizona does not have its own mandate; the federal penalty of $0 applies.

To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as coverage from a State or Federal Health Insurance Exchange.

For information regarding Health Care Reform and the individual Mandate, please contact Human Resources or visit www.cciio.cms.gov.

You may elect to "waive" coverage if you have access to coverage through another plan or you choose not to enroll in benefits. To waive coverage, log into EASE. It is important to note that if you waive our medical coverage, you must maintain medical/health coverage through another source. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be on October 1, 2023 or if a qualifying status change occurs.

Your Benefits *Your Choice.*

KE&G Construction, Inc. benefits program offers several plans to choose from through the EASE platform. Our plans include:

HEALTH	MONEY	PROTECTION
Medical	Health Savings Account (HSA)	Short Term Disability
Telemedicine	Healthcare Flexible Spending Account (FSA)	Long Term Disability
Dental	Limited Purpose Flexible Spending Account (LPFSA)	Voluntary Life / AD&D
Vision	Dependent Care Flexible Spending Account (DCFSA)	
Accident		
Critical Illness		
Hospital Indemnity		

Medical Benefits

- Three Medical plans through BCBS of AZ – 2 HDHP and 1 PPO.

Ancillary Benefits

- 2 PPO Dental plans through MetLife, 1 DHMO plan through Employers Dental Service
- 2 Vision plans through MetLife
- Telemedicine options are available to all employees who enroll in the BCBS of AZ medical plan
- Accident, Critical Illness and Hospital Indemnity are all available through MetLife
- Flexible Spending Accounts through HealthEquity
- Health Savings Account through HealthEquity (includes $15 employer contribution from KE&G Construction if you enroll in a HDHP and open an HSA with HealthEquity)

What You Pay, What We Pay

- KE&G Construction provides two different contributions in the system: one for Medical and a benefit allowance for those employees who waive medical to apply to certain ancillary services (Dental, Vision, FSA/HSA.)
- Deductions are taken weekly for 52 pay periods.

Self-Enrollment

- All employees self-enroll online for benefits through EASE. You may want your spouse present while using EASE– remember, your benefit choices impact the whole family.
- HR can provide you with assistance as needed. Benefits Enrollment instructions are included on page 5 in this guide.
- You'll be able to see your choices, the cost, and make changes before you save. The information you enter feeds directly to insurance carriers and payroll, so please be sure it is accurate.

ID Cards

Depending on your enrollment choices, you may receive the following ID cards, which will be mailed to your home address (please be sure to always keep it updated):

You will receive a card if you enrolled in:

- BCBS of AZ: Medical
- Employer Dental Services (EDS) – DHMO

You will not receive a card if you enrolled in:

- MetLife; Dental
- MetLife: Vision

How To Enroll

Ease Enrollment Guide at a Glance

1. Log in to Ease per the instructions emailed to you from KE&G Benefits Administration. For optimal performance it is recommended that you use

Chrome or Firefox as your browser.

2. Click Start Enrollment to begin your enrollment.

3. Follow the prompts on each page to complete your benefit enrollment.
Click Continue to proceed to the next section.

4. Verify your personal information is correct and enter in any of your dependent information.

5. If requested during the enrollment process, provide any emergency contacts, employment documents, Medicare status, previous/current coverage and/or health information.

6. Please Select your benefit by selecting Enrolled or Waived for each plan.
Click Continue to proceed to the next benefit.

7. You will then be prompted to provide any missing data. Once you have done this, you will be able to review and sign your forms using your mouse or mobile device. Sign Forms

8. Before you review your forms

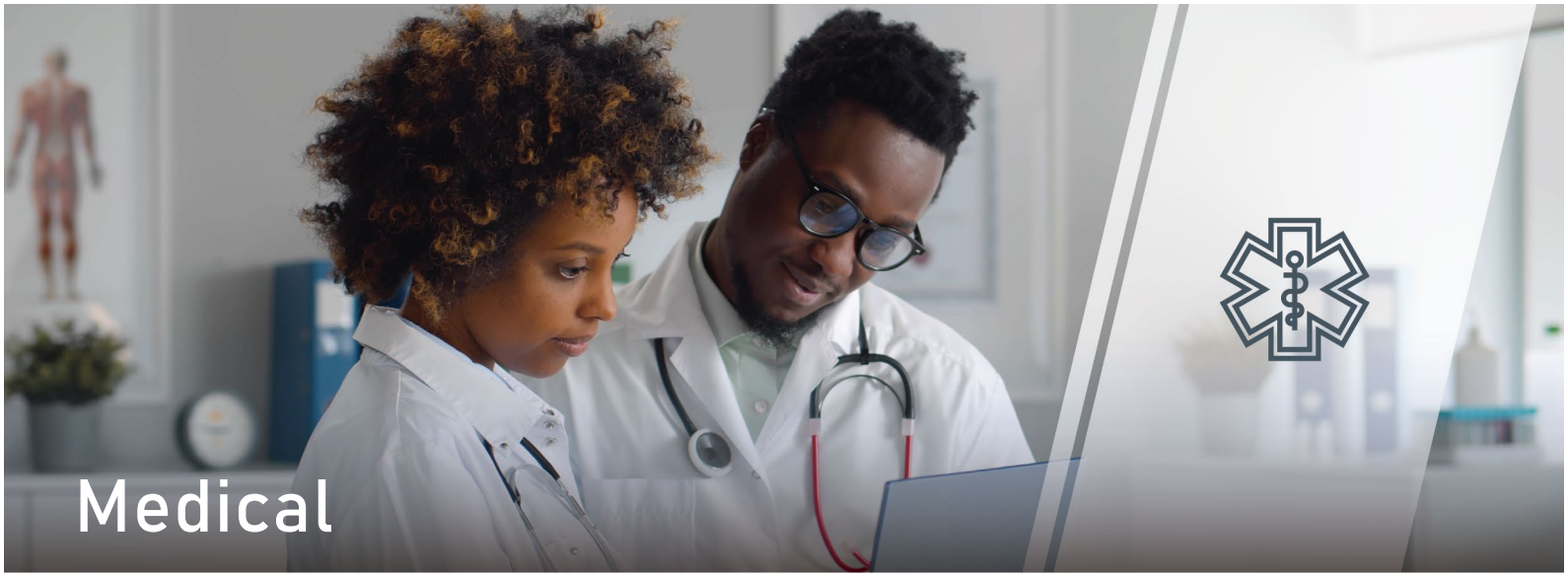
type your name.

THEN

Sign your signature

and follow the prompts to finish.

9. If you have questions, reach out to your HR administrator or Broker.



Medical

What are my options?

KE&G Construction offers 3 medical plans (2 HDHP and 1 PPO) through **BCBS of AZ.** Use the chart below to compare medical plan options and determine which would be the best for you and your family.

	HDHP	PPO
	BCBS of AZ	**BCBS of AZ**
Required to select and use a Primary Care Physician (PCP)	No	No
Seeing a Specialist	No referral required	No referral required
Deductible Required	Yes	Yes, in most cases
Claims Process	PPO network providers will submit claims. You submit claims for other services.	PPO providers will submit claims You submit claims for other services
Compatible with your Health Savings Account (HSA)	Yes	No, unless PPO is also a HDHP
Compatible with your Flexible Spending Account (FSA)	Yes, Flexible Spending Limited Purpose Account & Dependent Care Account	Yes, Flexible Spending Health & Dependent Care Account
Other Important Tips	• You may choose in or out-of-network care, however in-network care provides you a higher level of benefit. • Emergencies covered worldwide. • Out-of-network providers will bill the balance to the member for amounts not covered by BCBS of AZ. • The HSA account provides a tax-favored vehicle to help you manage your out-of-pocket expenses.	• You may choose in or out-of-network care, however in-network care provides you a higher level of benefit. • Emergencies covered worldwide. • Out-of-network providers will bill the balance to the member for amounts not covered by BCBS of AZ.

TIP

Medical Services Covered in Full

The federal Health Care Reform law now requires insurance companies to cover preventive care services in full, saving you money and helping you maintain your health. Preventive services may include annual check-ups, well-baby and child visits and certain immunizations and screenings.

To confirm that your preventive care services are covered, refer to your plan documents.

Medical Plans

KE&G Construction provides a selection of medical plans offering quality, flexibility, and value. Choose the plan that best meets your needs. Review the chart below for additional coverage details.

Plan Highlights	BCBSAZ HSA $4,000 (HDHP)	BCBSAZ HSA $3,000 (HDHP)	BCBSAZ PPO $3,500
	In-network Only	**In-network**	**In-network**
Annual Plan Year Deductible			
Individual	$4,000	$3,000	$3,500
Family	$8,000	$6,000	$7,000
Maximum Plan Year Out-of-pocket (1)			
Individual	$6,550	$3,500	$6,000
Family	$13,100	$7,000	$12,000
Professional Services			
Primary Care Physician (PCP)	10% after ded	0% after ded	$25 copay
Specialist	10% after ded	0% after ded	$50 copay
Telehealth Visit	10% after ded	0% after ded	$25 copay
Preventive Care Exam	$0	$0	$0
Diagnostic X-ray and Lab	10% after ded	0% after ded	$25
Complex Diagnostics (MRI/CT Scan)	10% after ded	0% after ded	20% coinsurance after ded
Chiropractic Services	10% after ded	0% after ded	$50 copay
Hospital Services			
Inpatient	10% after ded	0% after ded	20% coinsurance after ded
Outpatient Surgery	10% after ded	0% after ded	20% coinsurance after ded
Urgent Care	10% after ded	0% after ded	$60 copay
Emergency Room	10% after ded	0% after ded	$250 copay
Mental Health & Substance Abuse			
Inpatient	10% after ded	0% after ded	20% coinsurance after ded
Outpatient	10% after ded	0% after ded	$25 / $50 (copay varies based on specialty)
Retail Prescription Drugs (30-day supply)			
Tier 1	$10 copay, after ded	$10 copay, after ded	$15 copay
Tier 2	$30 copay, after ded	$20 copay, after ded	$35 copay
Tier 3	$50 copay, after ded	$40 copay, after ded	$65 copay
Tier 4			
Level A:	$30 copay, after ded	$30 copay, after ded	$50 copay
Level B:	$60 copay after ded	$60 copay after ded	$100 copay
Level C:	$90 copay after ded	$90 copay after ded	$150 copay
Level D:	$120 copay after ded	$120 copay after ded	$200 copay

Employee Cost Per Pay Period			
Employee Only	$15.00	$15.00	$44.77
Employee + Spouse	$39.49	$62.54	$92.31
Employee + Child(ren)	$34.38	$56.31	$91.85
Family	$45.23	$74.31	$136.62

Please note, the above examples are used for general illustrative purposes only. Please consult with your Human Resources department for more specific information as it relates to your specific plan. For a detailed view of your medical plan summaries, visit wwwkeg.ease.com.

How to Find a Provider

BCBSAZ

1. Go to azblue.com and click “Find a Doctor”
2. Choose “I am NOT yet a member,” then click on the box that reads “But might get a BCBSAZ health plan through my employer.”
3. Click on the arrow next to “Choose a Network.”
4. Choose PPO or EPO then click “Search.”
5. You are now ready to search for a provider.

Remember, if you don’t log in or create an account, you may get search results showing healthcare facilities and professionals that are not in your plan’s network.

Prescription Drug Coverage

Many FDA-approved prescription medications are covered through the benefits program. Important information regarding your prescription drug coverage is outlined below:

- The BCBS of Arizona plan covers generic formulary, brand-name formulary, non-formulary brand, and specialty drugs.
- Generic drugs are required by the FDA to contain the same active ingredients as their brand-name counterparts.
- A brand-name medication is protected by a patent and can only be produced by one specified manufacturer.
- Although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company’s preferred formulary list.
- Specialty medications most often treat chronic or complex conditions and may require special storage or close monitoring.

For a current version of the prescription drug list(s), go to www.azblue.com.

WHY PAY MORE?

There are a few ways you can save money when using the Prescription Drug Plan:

Mail Order

Save time and money by utilizing a mail order service for maintenance medications. A 90-day supply of your medication will be shipped to you, instead of a typical 30-day supply at a walk-in pharmacy.

Shop Around

Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. By calling ahead, you may determine which pharmacy provides the most competitive price.

Explore Over-the-Counter Options

For common ailments, over-the-counter drugs may provide a less expensive option that serves the same purpose as prescription medications.

Telehealth Services

With telehealth, you can connect with leading board-certified physicians for many non-emergency illnesses through the internet or telephone. By leveraging these virtual visits, you can avoid emergency rooms and urgent care centers and quickly refill your prescriptions so you can get back on your feet in no time.

Telehealth can be used for:

General Health Issues

Certain Specialty Services

Prescription

If your telehealth doctor prescribes you medication, Bluecare Anywhere will ensure you are able to conveniently pick up your prescription in your local area. You may also use mail-order services for delivery of your prescription.

There is no charge for medical telehealth consultations for the BCBSAZ PPO Plan if services are rendered through BlueCare Anywhere.

Through BlueCare Anywhere, telehealth services for HDHP plans is shown below: Rates are based on provider specialty and service.

HDHP Consultation Unit Description	Rate
Urgent Care, General Consult	$ 64.00
Pyschotherapy - Masters Level	$ 90.00
Pyschotherapy - Doctorate Level	$ 115.00
Psychiatry - Initial Visit (~45 mins)	$ 250.00
Psychiatry - Initial Visit (~30 mins)	$ 140.00
Psychiatry - Initial Visit (~15 mins)	$ 95.00
Registered Dietician	$ 65.00
Lactation Consultant Initial Visit (~50 mins)	$ 115.00
Lactation Consultant Initial Visit (~25 mins)	$ 69.00

Start your eVisit today!

- By Phone: 844.606.1612
- Group#; 034914
- Online: www.bluecareanywhereaz.com
- Download BlueCare Anywhere mobile app

Workplace Wellness

Why Wellness?

Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual health care costs. We care about your total well-being and encourage all employees to engage in our Wellness Program at no-cost.

Sharecare

Blue Cross® Blue Shield® of Arizona has partnered with Sharecare, an award-winning digital health solution, to provide you simple tools to manage all your health and wellness needs in one place. You'll start by taking the RealAge health assessment to get a measure of the true age of your body in terms of health and vitality, versus your calendar age. The program then delivers personalized insights, challenges, daily tracking, and one-of-a-kind tools to help you reduce your RealAge and live healthier, no matter where you are in your health journey.

Learn what you need to be healthier with tips on how to eat better, exercise smarter, reduce stress, and more. The Sharecare app recommends simple things you can do every day and reminds you to do them.

Take Control of Your Health

Go to **azblue.sharecare.com** to register. You'll need your insurance ID or Health & Wellness ID. Once registered, you can download the Sharecare app to have easy access to everything at your fingertips!

- **Manage your health profile**: One convenient location with all your essential health information, including your prescriptions, medical conditions, and test results.
- **Get personalized recommendations**: Challenges, tips, articles, and videos based on your health needs as identified in your RealAge test results.
- **Stay supported and motivated:** Expert guidance and accountability when you need it, with achievable goals and rewards to help you lower your RealAge.
- **Feel Secure:** Sharecare keeps your account private and secure. You own your health data, and you decide whom you want to share it with.

Find out your RealAge today! azblue.sharecare.com

Spending Accounts

Health Savings Account (HSA)

What is it?

By enrolling in the BCBS of AZ high-deductible health plan, you will have access to a Health Savings Account (HSA), which provides tax advantages and can be used to pay for qualified health care expenses, such as your deductible, copayments, and other out-of-pocket expenses.

What are the benefits?

Administered by HealthEquity, an HSA accumulates funds that can be used to pay current and future health care costs.

- Payroll deductions are available to you on a pre-tax basis.
- Generally, HSA funds can grow on a tax-free basis, subject to state law.[1]
- An HSA reduces your taxable income and may allow you to make tax-free withdrawals from the account when paying for qualified health care expenses (tax regulations vary by state).
- Because you own the HSA, there are no "Use it or Lose it" provisions, so unused HSA funds roll over from year-to-year and can be used to reimburse future eligible out-of-pocket expenses.
- You may enjoy lower monthly premium payments as compared to traditional PPO medical plans.
- Because you own the HSA, the money in your account is yours to keep if you leave the company.
- **KE&G Construction contributes $15 per week** for employees enrolled in the HDHP/HSA plans as long as you meet IRS eligibility. Employees must elect to enroll in Health Equity to receive this contribution. This contribution applies towards the annual IRS contribution limits.

Employee Weekly Spend	HSA $4,000 Pre KE&G HSA Contribution	HSA $4,000 After KE&G HSA Contribution	HSA $3,000 Pre KE&G HSA Contribution	HSA $3,000 After KE&G HSA Contribution	PPO $3,500
Employee Only	$15.00	$0.00	$15.00	$0.00	$44.77
Employee + Spouse	$39.46	$24.46	$62.54	$47.54	$92.31
Employee + Child(ren)	$34.38	$19.38	$56.31	$41.31	$91.85
Employee + Family	$45.23	$30.23	$74.31	$59.31	$136.62

The above chart is for illustration purposes only. The blue column is the amount that will be deducted from your check and the orange column is representative of your net cost after KE&G's contribution to your HSA account.

How do I qualify for an HSA?

The IRS has guidelines regarding who qualifies for an HSA. You are considered eligible if:

- You are covered under a qualified medical plan.
- You are not enrolled in non-qualified health insurance outside of KE&G Construction HDHP plan.
- You are not enrolled in Medicare.
- You are not claimed as a dependent on someone else's tax return (excluding a spouse).
- You are not enrolled in a general Health Care Flexible Spending Account (Health FSA) or general Health Reimbursement Arrangement (HRA).

How do I get started?

If you're ready to activate your HSA, you can do so by:

- Enroll in a BCBS of AZ High Deductible Health Plan.
- Enroll in the Health Savings account in EASE.

Once the HSA is activated, you can manage and access your account at any time by visiting www.healthequity.com. If questions arise regarding account activation, contact HealthEquity 866-382-3510 or visit www.healthequity.com. Consult your tax advisor for taxation information or advice. HealthEquity HSA Policy# 39709.

(1) Please consult your tax advisor for applicable tax laws in your state

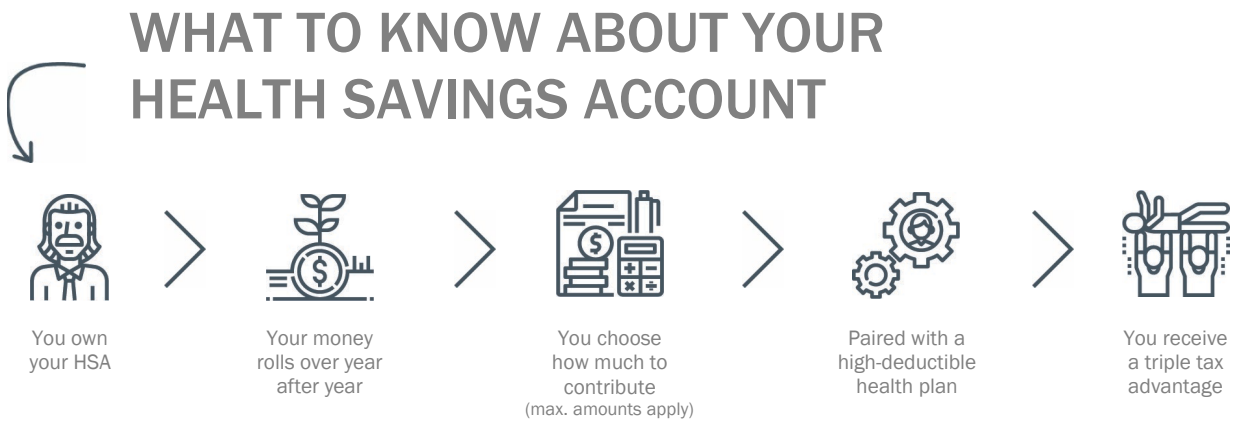
A few rules you need to know:

- For 2022, the maximum contribution limit for employee and employer contributions in an employee's HSA account is $3,650 if you are enrolled in the HDHP for employee-only coverage, and $7,300 for employees with dependent coverage. If you are age 55 and over, you may contribute an additional $1,000
- It's important to monitor your contributions to avoid going over the IRS limit, as contributions in excess of the IRS limit are subject to standard income tax rates, plus a 6% excise tax.
- There is a 20% penalty for using HSA funds on non-qualified health care expenses if you are under age 65. For more details about what are considered qualified health care expenses, visit www.irs.gov or www.Healthequity.com.
- You may not be able to contribute to your HSA if you are entitled to Medicare. However, funds accumulated before Medicare entitlement may be used to reimburse your qualified medical expenses.
- You may not contribute to your HSA if you are covered under any medical benefits plan which is not an HSA-qualified high deductible medical plan (e.g., a spouse's non-HDHP medical plan, a general purpose Health Care FSA, or Medicare). However, you may be covered by a Limited Purpose Health Care FSA, or an FSA which can be used after your HDHP deductible is met.
- Typically, the maximum amount an employee is eligible to contribute to an HSA per calendar year is based upon a **pro-rata** portion of the number of months an employee is eligible to contribute to an HSA. For example, an employee would normally be able to contribute 4/12 of the maximum annual limit in his/her first year of enrollment into the HSA plan, if the employee first joins the HSA plan on September 1. However, under the full contribution rule, an employee is allowed to contribute the maximum annual amount, regardless of the number of months he/she was eligible to contribute to an HSA in the first year, if he/she is eligible to contribute to an HSA on December 1 of the first year and continues to be eligible to contribute to an HSA until December 31 of the following year (i.e., for the entire subsequent year).

TIP

How do I manage my HSA?

- **The most convenient way to pay for qualified expenses is to utilize the debit card**
- **You can also use your own cash or a personal credit card and reimburse yourself through your online HSA account**
- **It is recommended that you keep receipts of HSA purchases, should you ever be audited by the IRS**
- **View the status of your claims and check your HSA balance at www.healthequity.com**



Flexible Spending Accounts (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible health care, dependent care, expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA Type	Detail
Health Care FSA	• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance. • Maximum contribution for 2022 is $2,850.
Limited Purpose FSA	• Option for employees enrolled in a Health Savings Account (HSA) eligible plan. • Use this FSA to reimburse for eligible preventive care, dental and vision expenses. • Maximum contribution for 2022 is $2,850.
Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) childcare expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Maximum contribution for 2022 is $5,000.

What are the benefits?

- Your taxable income is reduced and your spendable income increases!
- Save money while keeping you and your family healthy.

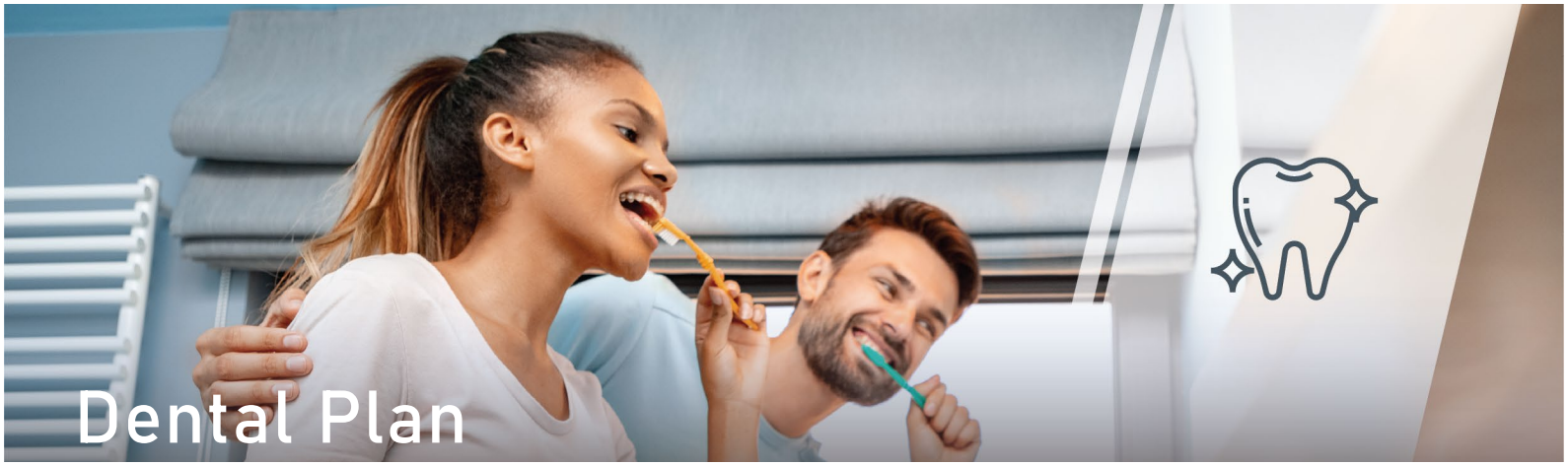
How do I use it?

You must enroll in the FSA program within 30 days of your hire date or during annual open enrollment. At this time, you must establish an annual contribution amount within the maximum limit. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status, and more. Visit HealthEquity/Wageworks at www.wageworks.com to access HealthEquity / Wageworks online portal.

A few rules you need to know:

- You may carryover up to $500.00 from your 2022 Health FSA to the 2023 plan year.
- Although the FSA plan year runs October 1, 2022 through September 30, 2023, you will have extra time after the end of the plan year to seek reimbursement for health care expenses incurred during the plan year. This reimbursement period is called an annual run-out period.

For more details about using an FSA, contact HealthEquity / Wageworks at 877-924-3967.



Dental Plan

Your Dental DHMO & PPO Plan

You and your eligible dependents will have the opportunity to enroll in a Dental Health Maintenance Organization (DHMO) plan offered by Employer Dental Services or a Dental Preferred Provider Organization (PPO) plan offered by MetLife. We encourage you to review the coverage details and select the option that best suits your needs.

Plan Highlights	EDS Dental DHMO	MetLife Basic Dental PPO	MetLife Enhanced Dental PPO
	In-Network Only	In-Network	In-Network
Plan Year Deductible			
Individual	None	$0	$0
Family	None	$0	$0
Annual Maximum	N/A	$1,000	$1,500
Preventive	See Schedule*	0%	$0
Basic Services	See Schedule*	20%	10%
Major Services	See Schedule*	50%	40%
Orthodontia Services			
Adult	Not Covered	Not Covered	50%
Child up to age 19	See Schedule*	Not Covered	50%
Lifetime Maximum	See Schedule*	Not Covered	$2,000
Employee Cost Per Pay Period			
Employee Only	$2.48	$5.75	$8.24
Employee + Spouse	$4.94	$11.71	$16.79
Employee + Child(ren)	$6.46	$12.83	$18.40
Family	$7.45	$20.10	$28.83

*To obtain a copy of the 700N fee schedule or dental summary, please logon to the EASE Enrollment platform www.keg.ease.com.

TIP

Choose your Primary Care Dentist – EDS DHMO

In order to receive dental coverage when using a DHMO, it's important that you determine whether the dental office is in a network that your insurance covers your home location. To confirm you've found a dentist in the right network, visit www.employersdental.com or call Employers Dental Services 800-722-9772.

MetLife DPPO

When using a Dental PPO plan, you can receive services from dental providers both in and out of your insurance network. However, you'll receive better coverage when you use an in-network dentist. To determine whether your dentist is in or out of your insurance network, go to www.metlife.com and search the MetLife network, or call MetLife at 800-275-4638.

Vision Plan

There are two vision plans offered through MetLife, as a Preferred Provider Organization (PPO) plan. As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount. To locate an in-network vision provider, visit www.metlife.com.

To view a complete plan summary, www.keg.ease.com

Plan Highlights	MetLife Vision PPO 130A	MetLife Vision PPO 150A
	In-Network	**In-Network**
Exam – Every 12 months	$10	$5
Materials Copay	$25	$10
Lenses – Every 12 months		
Single	100% after $25 eyewear copay	100% after $10 eyewear copay
Bifocal		
Trifocal		
Frames – Every 12 months		
Frames	$130 Allowance after $25 eyewear copay then 20% discount on balance	$150 Allowance after $10 eyewear copay then 20% discount on balance
Frame Benefit at specific retailers • Costco • Walmart • Sam Club	$85 allowance after $25 eyewear copay then 20% discount on balance	$85 allowance after $10 eyewear copay then 20% discount on balance
Contacts – Every 12 months, in lieu of lenses & frames		
Medically Necessary	Covered in full after $25 eyewear copay	Covered in full after $10 eyewear copay
Elective	$130 Allowance on material	$150 Allowance on materials
Contact lens fitting and evaluation	Covered in full with a max copay of $60	Covered in full with a max copay of $60

Employee Cost Per Pay Period		
Employee Only	$1.98	$2.41
Employee + Spouse	$3.96	$4.83
Employee + Child(ren)	$3.36	$4.08
Family	$5.53	$6.74

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

To find a vision provider, visit https://mymetlifevision.com

Life and Disability

Basic Life and AD&D

In the event of your passing, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Paid for in full by KE&G Construction, the benefits outlined below are provided by MetLife:

- Basic Life Insurance of $25,000.
- AD&D of $25,000.
- Please note, benefits may reduce when you reach age 65.

IRS Regulation: Employees can receive employer paid life insurance up to $25,000 on a tax-free basis and do not have to report the payment as income.

Voluntary Life and AD&D

If you would like to supplement your employer paid insurance, additional Life and AD&D coverage for you and/or your dependents is available for purchase on a payroll deduction basis through MetLife.

- **For employees:** Increments of $25,000 up to a $500,000 maximum, not to exceed 5 times your salary. The guaranteed issue benefit of $150,000 if you enroll in the plan within 30 days of your initial eligibility.
- **For your spouse:** Increments of $5,000 up to a $250,000 maximum, not to exceed 50% of employee benefit. The guaranteed issue benefit of $50,000 if you enroll in the plan within 30 days of your initial eligibility.
- **For your child (ren):** Increments of $1,000, $2,000, $4,000 and $10,000; All amounts are guaranteed issue.
- **Voluntary AD&D:** Coverage is available for purchase in the same amounts as voluntary life insurance amounts above.

Any amounts of insurance over the guaranteed issue benefit are subject to review of good health by the insurance company. Insurance amounts subject to review will not be effective until the insurance company approves.

If you do not enroll in the plan within the initial enrollment period, **any** amount of supplemental life insurance will require proof of good health, which is subject to approval by the insurance company before the insurance is effective. For more information regarding this plan, review the plan summary detail.

Please note: Benefits coverage may reduce when you reach age 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.

TIP

Required! Are Your Beneficiaries Up to Date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- **You can change your beneficiary designation at any time.**
- **You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.**
- **To select or change your beneficiary, log on to www.keg.ease.com or contact Human Resources.**

Short & Long Term Disability

Added Protection

Should you experience a non-work-related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation.

Your Plans	Coverage Details
Short Term Disability (STD)	• Administered by MetLife, STD coverage provides a benefit equal to 60% of your earnings, up to $2,000 per week for a period up to 11 weeks. • The plan begins paying these benefits at the time of disability/after you have been absent from work for 14 consecutive days.
Long Term Disability Coverage (LTD)	• If your disability extends beyond 90 days, the LTD coverage through MetLife can replace 60% of your pre-disability earnings, up to maximum of $10,000 per month. • Your benefits may continue to be paid until you reach social security normal retirement age, or the period shown in the MetLife Certificate, as long as you meet the definition of disability.

100% Employee-paid

As an optional employee paid benefit, disability coverage is available to you on a post-tax basis. By paying for your disability coverage on a post-tax basis, you will not have to pay income taxes on any STD and/or LTD benefits you receive.

Please note: Consult your tax advisor for additional taxation information or advice.

Supplemental Health

Critical Illness Coverage

Critical Illness coverage offered on a voluntary basis through MetLife pays you a lump sum benefit if you are diagnosed with a covered illness or condition. All benefits are paid directly to you, and you may use the funds as you see fit.

What can Critical Illness coverage pay for?

- Medical expenses, such as copays, deductibles, or co-insurance
- Lost Income
- Everyday expenses such as groceries and utilities
- Alternative treatments
- Lodging and travel to a specialist

What are examples of covered illnesses or conditions?

- Cancer
- Heart Attack
- Stroke
- Alzheimer's
- Kidney Failure
- Organ Transplant

Here's an example of how Critical Illness coverage can help support you

Denise is 45 years old and had a heart attack. She was out of work for a couple of months recovering and although she had disability insurance, it did not cover all of her lost income and medical bills. Thankfully, Denise had a $10,000 Critical Illness policy. She filed her claim and received her cash benefit so that she could pay her bills and medical expenses. With her Critical Illness policy, Denise had peace of mind and was able to focus on improving her health.

100% Employee-paid

If you elect the voluntary Critical Illness plan, 100% of the cost is deducted through weekly pre-tax payroll deductions.

Health Screening Benefit

After your coverage has been in effect for thirty days, MetLife will provide an annual benefit* of $50 or $100 per calendar year for taking one of the eligible screening/prevention measures. MetLife will pay only one health screening benefit per covered person per calendar year.

*The Health Screening Benefit amount depends upon the Initial Benefit Amount selected. Employees would receive a $50 benefit with the $15,000 initial benefit amount or a $100 benefit with the $30,000 Initial Benefit Amount.

Benefit options

Election	Benefit Amounts & Guaranteed Issue
Employee	$15,000 or $30,000 (All Guaranteed Issue)
Spouse	Up to 50% of Employee benefit election (All Guaranteed Issue)
Child(ren)	Children are automatically covered at 50% of employee

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. To learn more or to obtain a full schedule of benefits and rates, contact Human Resources or reach out to MetLife directly at 800-438-6388.

Hospital Protection

Planned or unplanned, a trip to the hospital can be unsettling, especially if your primary medical insurance doesn't cover the majority of your costs. Hospital Insurance offered on a voluntary basis through MetLife pays out cash to you or your family to offset both medical and non-medical bills resulting from a hospital stay.

How can Hospital insurance help?

The cash benefits can be used to pay for services or expenses your traditional medical plan might not cover. Since benefits are paid directly to you, you choose how to use them. Here are a few examples:

- Copayments
- Deductibles
- Transportation expenses
- Childcare
- Lodging expenses for a companion
- Lost income

Here's an example of how Hospital Insurance can help support you

Meet Trevor. Trevor had some complications from gallbladder removal surgery, which resulted in a 5-day hospital stay. Through his primary medical insurance, Trevor owed a $3,000 deductible and $3,000 in co-insurance. With the help of his Hospital Insurance coverage, which paid a $1,000 admission benefit plus $200 for each additional day, he was only out of pocket $4,200 instead of $6,000.

Out-of-Pocket Expenses	Hospital Indemnity Plan Benefits
$3,000 deductible	$1,000 admission benefit
$3,000 co-insurance	$200/day x 4 additional days = $800
Total: $6,000	**Total benefits paid to Trevor: $1,800**

Please note the above is an illustration only and does not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.

100% Employee-paid

If you elect the voluntary Hospital Insurance plan, 100% of the cost is deducted through payroll deductions. Weekly pre-tax rates are outlined below:

Employee Cost per Pay Period	Low Plan	High Plan
Employee Only	$3.81	$7.61
Employee + Spouse	$7.54	$15.07
Employee + Child(ren)	$6.89	$13.78
Family	$11.72	$23.44

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. To learn more or to obtain a full schedule of benefits, contact Human Resources.

Accident Insurance Plan

Accident Insurance offered on a voluntary basis through MetLife provides coverage for specific injuries and treatments resulting from a covered accident. The amount of the benefit paid depends on the type of injury and care received.

How can Accident Insurance help?

Since benefits are paid directly to you, you choose how to use them, such as paying medical bills, subsidizing lost income, or covering everyday expenses.

What are some common covered benefits?

- Emergency room visit.
- Ambulance
- Doctor visits.
- Hospital admission.
- Surgery.
- Medical equipment.
- Outpatient therapy.

Here's an example of how Accident Insurance can help support you

Diagnostic Imaging Covered Event/Injury	Benefit Amount
Ambulance (ground)	$300
Emergency room care	$100
Physician follow-up ($75 x 2)	$150
X-ray	$50
Concussion	$400
Broken tooth (repaired by crown)	$200
Total benefit paid by Kathy's Accident Plan	**$1,200**

Kathy's daughter, Molly, plays soccer. During a recent game, she collided with a player, was knocked unconscious and taken to the emergency room (ER) by ambulance. The ER doctor diagnosed a concussion and a broken tooth. He ordered an x-ray scan to check for facial fractures due to swelling. Molly was released to her primary care physician for follow-up treatment and her dentist repaired her broken tooth with a crown. Thanks to Accident Insurance, Kathy will receive $1,200 to help pay for Molly's expenses associated with her accident.

Please note the above is an illustration only and does not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.

100% Employee-paid

If you elect the voluntary Accident Insurance plan, 100% of the cost is deducted through payroll deductions. Weekly pre-tax rates are outlined below:

Employee Cost Per Pay Period	Low Plan	High Plan
Employee Only	$2.71	$5.23
Employee + Spouse	$4.46	$8.58
Employee + Child(ren)	$5.59	$10.75
Family	$7.04	$13.56

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. To learn more or to obtain a full schedule of benefits, contact Human Resources or MetLife directly at 800-438-6388.

Directory & Resources

Below, please find important contact information and resources for KE&G Construction.

Information Regarding	Group / Policy #	Contact Information	
Enrollment & Eligibility			
Human Resources: • Weslyn Bejarano / Senior Accountant Online Enrollment Vendor: • EASE		520.777.5875	wbejarano@kegtus.com https://keg.ease.com
Medical Coverage			
BCBS	034914	800.232.2345 English: Ext. 4456 Spanish: Ext. 4884	www.azblue.com
Telemedicine	034914	844.606.1612	www.bluecareanywhereaz.com
Wellness – ShareCare	034914	N/A	www.azblue.sharecare.com
Dental Coverage			
MetLife • DPPO	05939353	800.275.4638	www.metlife.com
EDS • DHMO	18900	800.722.9772	www.employersdental.com
Vision Coverage			
MetLife • Vision PPO	05939353	800.275.4638	www.metlife.com
Life, AD&D and Disability			
MetLife • Basic Life / AD&D • Voluntary Life / AD&D • Voluntary Short-Term Disability • Voluntary Long-Term Disability	05939353	800.638.6420, Opt. 2	www.metlife.com
Flexible Spending Accounts			
HealthEquity / Wageworks	39709	877.924.3967	www.healthequity.com
Health Savings Account			
HealthEquity	25384	866.382.3510	www.healthequity.com
Worksite (Accident, Hospital, Critical Illness)			
MetLife • Accident • Hospital Indemnity • Critical Illness	0171475 0171475 0171474	888.888.8888	www.metlife.com
401(k) Retirement Plan Adviser			
Fidelity – 401k	N/A	844.203.2402	www.netbenefits.com
Benefits Broker / Benefit Questions			
Lovitt & Touché, A Marsh & McLennan Insurance Agency LLC Claims Advocate (Catherine Nault)		520.722.7155	cnault@lovitt-touche.com

Guidelines/Evidence of Coverage

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

Summary of Material Modifications

The following changes will apply effective on a group's plan year anniversary on and after October 1, 2022:

Preventive Services

Federal law often requires changes to the list of preventive services and medications covered under this benefit plan. Information on covered preventive services will be in the Preventive Services section of your Benefit Book. Note that covered preventive services may change at any time. If you have questions about your plan's covered preventive services, you can download your Benefit Book from your MyBlue℠ account at **azblue.com/myblue**:

- Log in to your MyBlue account
- Click "Plan Benefits"
- Under "Benefit Documents", look for the file called "Benefit Book [PDF]"

For information about preventive drugs covered under this benefit plan, visit **azblue.com/pharmacy**.

REQUIRED NOTICES

Medicare Part D
Creditable Coverage Notice

Important Notice from KE&G Construction About Your Prescription Drug Coverage and Medicare

Group ID	Group Name	Effective Date	Plan Name	When Medicare Medical Pays	
				Primary	Secondary
034914	KE&G CONSTRUCTION	10/1/2021	HSA 3000	Not Credible	Creditable
034914	KE&G CONSTRUCTION	10/1/2021	HSA 4000	Not Credible	Creditable
034914	KE&G CONSTRUCTION	10/1/2021	PPO 3500	Creditable	Creditable

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with KE&G Construction, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **KE&G Construction, Inc. has determined that the prescription drug coverage offered by the KE&G Construction, Inc.is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan while enrolled in KE&G Construction, Inc. coverage as an active employee, please note that your KE&G Construction, Inc. coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in KE&G Construction, Inc. coverage as a former employee.

You may also choose to drop your KE&G Construction, Inc. coverage. If you do decide to join a Medicare drug plan and drop your current KE&G Construction, Inc. coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with KE&G Construction, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through KE&G Construction, Inc. changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 10/01/2022
Name of Entity/Sender: KE&G Construction, Inc.
Contact--Position/Office: Weslyn Bejarano, Senior Accountant
Address: 3949 East Irvington Road, Tucson, Arizona 85714
Phone Number: 520-777-5875

Legal Information Regarding Your Plans

REQUIRED NOTICES

Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

"HIPAA Special Enrollment Opportunities" include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage [1]
- Acquisition of a new spouse or dependent through marriage [1], adoption [1], placement for adoption [1] or birth [1]
- Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) [1]
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

"Change in Status" Permitted Midyear Election Changes

- Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved "change in status" as defined by the IRS.
- Examples of permitted "change in status" events include:
- Change in legal marital status (e.g., marriage [2], divorce or legal separation)
- Change in number of dependents (e.g., birth [2], adoption [2] or death)
- Change in eligibility of a child
- Change in your / your spouse's employment status (e.g., reduction in hours affecting eligibility or change in employment)
- A substantial change in your / your spouse's benefits coverage
- A relocation that impacts network access
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment
- Qualified Medical Child Support Order or other judicial decree
- A dependent's eligibility ceases resulting in a loss of coverage [3]
- Loss of other coverage [2]
- Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage
- You enroll, or intend to enroll, in a Qualified health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

You must notify Human Resources within 30 days of the above change in status, with the exception of the following which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

IMPORTANT INFORMATION ON HOW HEALTH CARE REFORM AFFECTS YOUR PLAN

Prohibition on Excess waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

[1] Indicates that this event is also a qualified "Change in Status"
[2] Indicates this event is also a HIPAA Special Enrollment Right
[3] Indicates that this event is also a COBRA Qualifying Event

CONTINUATION COVERAGE RIGHTS UNDER COBRA (CONTINUED)

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

COBRA Administer

Insight COBRA

P.O. Box 733862

Dallas, TX 75373-3864

(855) 266-2092

insightcobra@boonchapman.com

How is COBRA continuation coverage provided? (Continued)

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period [(1)] to sign up for Medicare Part A or B, beginning on the earlier of

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

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

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

KE&G Construction, Inc.
Attention: Weslyn Bejarano
Senior Accountant
3949 East Irvington Road
Tucson, Arizona 85714
(520) 777-5875

For More Information

This notice doesn't fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact your Human Resources Representative.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.healthcare.gov.

EMPLOYEE RIGHTS & RESPONSIBILITIES UNDER THE FAMILY MEDICAL LEAVE ACT

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

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

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness [1]; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. [1]

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months [2], and if at least 50 employees are employed by the employer within 75 miles.

[1] The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition"

[2] Special hours of service eligibility requirements apply to airline flight crew employees

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TYY: (877) 889-5627
www.wagehour.dol.gov

UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT NOTICE OF 1994, NOTICE OF RIGHT TO CONTINUED COVERAGE UNDER USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You do not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Reporting to Work / Applying for Reemployment

Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible
181 days or more	Submit an application for reemployment within 90 days after completion of your service
Any period if for purposes of an examination for fitness to perform uniformed service	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definitions

For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency
- "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

HIPAA PRIVACY NOTICE

Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice is EFFECTIVE: October 1, 2022.

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to provide information about the legal protections that apply to your health information. HIPAA includes numerous provisions that are designed to maintain the privacy and confidentiality of your Protected Health Information (PHI). PHI is health information that contains identifiers (such as your name, address, social security number, or other information that identifies you) and information related to your past, present or future health condition and treatments.

This notice is for participants in the Company Health & Welfare Plan (referred to as the "Plan"), including its component plans.

Required by Law

- The Plan must make sure that health information that identifies you is kept private.
- The Plan must give you this notice of our legal duties and privacy practices with respect to health information about you.
- The Plan must obtain written authorization from you for the use and disclosure of your PHI related to psychotherapy notes; when for purposes of marketing; and/or for disclosures constituting a sale of PHI.
- The Plan must follow the terms of the notice that are currently in effect.

Permitted Plan use of Your Health Information

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact the Plan Privacy Officer.

You have both the right and choice to tell us to: share information with your family, close friends, or others involved in payment for your care; share information in a disaster relief situation; and contact you for fundraising efforts.

If you are not able to tell us your preference, for example if you are unconscious, the Plan may go ahead and share your information if it believes it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety.

The Plan will never share your information unless you give us written permission for: marketing purposes and the sale of your information.

Treatment: The Plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the Plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees. We may also use and disclose your information to run our organization and contact you when necessary. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. The Plan is also not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Payment for Health Services and Administration of the Plan: The Plan can use and disclose your health information when paying for your health services. For example, the Plan may share information about you with your dental plan to coordinate payment for your dental work. The Plan may disclose your health information to your health plan sponsor for plan administration. For example, where your company contracts with an insurer to provide a health plan, and the Plan provides your company with certain statistics to explain the premiums charged.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy rules and HIPAA security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law (this includes the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law).

To Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director: We may share health information about you with organ procurement organizations; and may share health information with a coroner, medical examiner, or funeral director when an individual dies.

Workers' Compensation: We may release health information about you for workers' compensation programs or claims or similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement and other Government Requests: We may disclose your health information for law enforcement purposes or with a law enforcement official, in response to a valid subpoena or other judicial or administrative request/order, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services.

Public Health and Research: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation). Additionally we may share health information about you when: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety or for purposes of health research.

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information where concerning a service already paid for.
- Obtain a paper copy of the notice of health information practices promptly (even if you have agreed to receive the notice electronically) by requesting it from the Plan Privacy Officer.
- Ask to see or get a copy of your health and claims records and other health information we have about you. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Inspect and obtain a copy of your PHI contained in a "designated record set." A designated records set includes medical and billing records; enrollment, payment, billing, claims adjudication and case or medical management record systems; or other information used in whole or in part by or for the covered entity to make decisions about individuals. A written request to access your PHI must be submitted to your company Privacy Officer. Requested information will be provided within 30 days if maintained on site or 60 days if maintained off site.
- Request an amendment/correction to your health information: you can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- **Obtain an accounting of disclosures of your PHI during the preceding six years, who we shared it with, and why, with the exception of disclosures made for purposes of treatment, payment or health care operations, and certain other disclosures (such as any you asked us to make); made to individuals about their own PHI; or, made through use of an authorization form. A reasonable fee may be charged for more than one request per year.**
- **Request confidential communications of your health information be sent in a different way (for example, home, office or phone) or to a different place than usual (for example, you could request that the envelope be marked "confidential" or that we send it to your work address rather than your home address). We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.**
- **Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.**
- **Receive notification within 60 days (5 day for California residents) for any breaches of your unsecured PHI.**
- **Assign someone as your medical power of attorney or your legal guardian, who can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.**

Plan Responsibilities

The Plan is required to maintain the privacy of PHI and to comply with the terms of this notice. The Plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you within 60 days of the effective date of any material change to the rights and duties listed in this notice. The Plan is required to:

- **Maintain the privacy and security of your health information.**
- **Make reasonable efforts not to use, share, disclose or request more than the minimum necessary amount of PHI needed to accomplish the intended purpose, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**
- **Follow the duties and privacy practices described in this notice with respect to information we collect and maintain about you and provide you a copy of the notice.**
- **Abide by the terms of this notice.**
- **Notify you if we are unable to agree to a requested restriction, amendment or other request.**
- **Notify you of any breaches of your protected health information that may have compromised the privacy or security of your information within 60 days (5 days for California residents).**
- **Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.**

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA. The plan is prohibited from using or disclosing PHI that is genetic information of an individual for any purposes, including underwriting.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Your Right to File a Complaint

If you believe your privacy rights have been violated, you can file a formal complaint with the Plan Privacy Officer; or with the U.S. Department of Health and Human Services (by mail or email). We will not retaliate against you and you will not be penalized for filing a complaint.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Contact Person

If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the Plan Privacy Officer. All requests must be submitted in writing to the address shown below.

KE&G Construction, Inc.
Attention: Weslyn Bejarano
Senior Accountant
3949 East Irvington Road
Tucson, Arizona 85714
(520) 777-5875

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more informationon eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center:1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA-Medicaid	**MAINE-Medicaid**
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084

LOUISIANA-Medicaid	NEBRASKA-Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA-Medicaid	**SOUTH CAROLINA-Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345,ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p- 10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

Notice Regarding Availability of Health Insurance Exchange

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(Expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.61% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after- tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name KE&G Construction, Inc.		4. Employer Identification Number (EIN) 20-5816819
5. Employer address 3949 East Irvington Road		6. Employer phone number 520-777-5875
7. City Tucson	8. State AZ	9. ZIP Code 85714
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above) 520-777-5874		12. Email address wbejarano@kegtus.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☒ All employees. Eligible employees are:

  Full-time regular employees working 30 hours or more per week

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

  Your legal Spouse, and dependent eligible children (up to age 26) or older who are or become disabled and dependent upon the employee.

  ☐ We do not offer coverage.

- ☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Prepared by: Marsh & McLennan Insurance Agency LLC
www.lovitt-touche.com