



2026 Non-Union Employee Benefit Guide



Medical | Dental | Vision | Life & AD&D | Voluntary Life
Disability | Health Savings Account | Paid Time Off | Employee
Assistance Program | Retirement | Additional Benefits

Welcome

At Global, we are committed to supporting the well-being of our employees and their families. This Benefit Guide is designed to help you understand and make informed decisions about the coverage and programs available to you. We encourage you to review your options and take full advantage of the benefits provided.

For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the Summary Plan Descriptions and official plan documents. If any discrepancy exists between this Guide and the official documents, the official documents will prevail.

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Important Contacts

FOR QUESTIONS ABOUT	CARRIER CONTACT	GROUP #	PHONE #	WEBSITE/EMAIL
Medical Insurance	BCBS of Kansas City	43684000	816-395-3558 888-989-8842	MyBlueKC.com
Pharmacy Coverage	BCBS of Kansas City	43684000	800-228-1436	MyBlueKC.com
Telemedicine / Virtual Care	BCBS of Kansas City	43684000	Available through MyBlueKC App	
Health Savings Account	Empower/Optum	E00563	800-331-5455	Empowermyretirement.com
Dental Insurance	Principal	1103065	800-247-4695	Principal.com
Vision Insurance	Carrier: Principal Network: VSP	1103065	800-247-4695 800-877-7195	Principal.com VSP.com
Life, AD&D, and Disability Insurance	Principal	1103065	800-245-1522	Principal.com
Employee Assistance Program (EAP)	Lucet	Company Code: Clarkson	800-624-5544	Eap.lucethealth.com
401(k) Recordkeeper	Empower	530841-01	800-338-4015	Empowermyretirement.com
401(k) Financial Advisor	Mariner Wealth Advisors (Patrick Sullivan)	N/A	913-647-9741	patrick.sullivan@mariner.com

If you have questions, concerns, or need support, please don't hesitate to reach out to HR.

Eligibility & Enrollment

Unless otherwise noted, all regular, full-time, non-union employees are eligible for the benefits described in this guide and coverage is effective on your first day of employment. New hires make benefit elections during the onboarding process. For all other employees, the annual open enrollment period is during the month of November for a January 1 effective date.

All benefit elections are made in the web version of your UKG portal.

Eligible Dependents

Your dependents are eligible for some of these benefits as well, where indicated. “Dependent” means:

- your legally recognized spouse
- Your dependent child under age 26. Dependent children can include your natural born child, step-child, legally adopted child, or child placed for adoption.

There may be other circumstances in which an individual would be considered a dependent. More information about this can be obtained from Human Resources. Coverage for eligible dependents begins on the same day your coverage is effective.

Making Changes to Your Benefit Elections

The benefits you elect at your time of hire (or open enrollment for existing employees) will be effective until the end of the current plan year. Once you have made your elections, you will not be able to make changes until the next open enrollment period, unless you experience a qualifying event status change. Qualifying events include, but may not be limited to:

- Changes in your legal marital status including marriage, death of your spouse, divorce, legal separation or annulment.
- Birth or adoption of a child.
- Your dependent satisfying or no longer satisfying the eligibility requirements due to age, or other circumstances.
- Loss of other coverage due to termination of employment, reduction in hours, exhaustion of COBRA or state continuation, or death.
- Becoming Medicare eligible.

You must notify Human Resources within 30 days from the date of any qualifying event status change in order to change your benefit elections!

Medical Benefits

Medical coverage helps keep you healthy and provides important financial protection if a medical need or condition occurs. The Company has partnered with Blue Cross Blue Shield of Kansas City (BCBSKC) for the care you need at a reasonable cost to help protect you against the catastrophic costs of major illness or injury.

You have up to three medical plan options; a Spira Care EPO plan (only available in the Kansas City area), a High Deductible Health Plan with an HSA (available nationally), and a traditional PPO plan (available nationally). Important details of each plan are below.

In every option it is best to in-network providers, who have pre-negotiated service fees, and to compare healthcare prices prior to receiving services. A complete listing of providers is available on MyBlueKC.com.



OPTION 1: Spira Care Exclusive Provider Organization (EPO)

Spira Care, developed by Blue Cross and Blue Shield of Kansas City, combines integrated primary care and coverage in one place. Members enjoy low premiums, relative to other plan options, and there are no costs for any services received at any of the nine KC Metro Spira Care Centers.

Spira Care members have two options for receiving care; visiting a Spira Care Center for primary care needs or seeing a provider in their plan's network. **Non-emergency services received out-of-network are not covered.** Members enrolling in Spira Care must live within the following 12-county service area:

- Kansas Counties: Johnson and Wyandotte
- Missouri Counties: Caldwell, Cass, Clay, Clinton, DeKalb, Jackson, Johnson, Lafayette, Platte and Ray

Kansas City Metro Locations for Spira Care Centers

Learn more about these locations, including extended hours and meet the Care Teams, at [SpiraCare.com](https://www.spiracare.com).



Spira Care Crossroads 1916 Grand Boulevard Kansas City, MO 64108
Spira Care Independence 3717 S Whitney Avenue Independence, MO 64055
Spira Care Lee's Summit 760 NW Blue Parkway Lee's Summit, MO 64086
Spira Care Liberty 8350 N Church Road Kansas City, MO 64158
Spira Care Olathe 15710 W 135th Street, Suite 200 Olathe, KS 66062
Spira Care Overland Park 7341 W 133rd Street Overland Park, KS 66213
Spira Care Shawnee 10824 Shawnee Mission Parkway Shawnee, KS 66203
Spira Care Tiffany Springs 8765 N Ambassador Drive Kansas City, MO 64154
Spira Care Wyandotte 9800 Troup Avenue Kansas City, KS 66111



OPTION 2: Qualified High Deductible Health Plan (QHDHP) & Health Savings Account (HSA)

QHDHPs are flexible PPOs that can pair with a tax-favored Health Savings Account (HSA), offering freedom to see any provider, though out-of-network care costs more. HSA plans don't require a primary care physician or referrals. Preventive care is fully covered, but all other healthcare, including prescriptions, is paid by you until the deductible is met.

HSA Benefits

- Contributions, interest, and withdrawals for qualified health expenses are tax-free
- Any unused money stays in your account each year and is always yours, regardless of employment status
- At age 65, HSA funds can be used penalty-free for any purpose (though non-medical uses are taxed) and can be used for Medicare premiums (Parts A, B, and D).

To participate in an HSA, you must

- Be enrolled in a QHDHP
- Not be claimed as a dependent on another's tax return
- Have no other non-QHDHP coverage (e.g., Medicare, Medicaid, Tricare)
- Not be covered by an FSA, including a spouse's

2026 HSA Contribution Limits

The table below shows the maximum amount that can be contributed to your HSA in 2026. All the money in your account is yours to spend on health care or save for future health care expenses. **The limits below include any Company contribution to your account.**

Coverage	Max. Contribution	Max. If 55+
Individual	\$4,400	\$5,400
Individual with dependents	\$8,750	\$9,750

2026 Company Contribution to Your HSA

To help cover potential out-of-pocket expenses, the Company makes weekly HSA contributions for employees who contribute to their HSA at any level. Weekly Company contributions are outlined below:

- Individual coverage: \$10 per week (\$520 annual equivalent)
- Individual with dependents coverage: \$20 per week (\$1,040 annual equivalent).

You can use your HSA to pay for expenses that generally qualify for medical, dental, or vision tax deductions, including:

- Deductibles, coinsurance, office visits, prescription drugs
- Hospital stays, lab work, therapy
- Dental and vision care

For a complete list of eligible expenses, go to www.irs.gov/publications/p502



OPTION 3: Preferred Provider Organization (PPO)

A PPO offers you the freedom to receive care from any provider, in or out of your network. This means you can see any doctor or specialist, or use any hospital, though you will be charged significantly more out of network. In addition, PPO plans do not require you to choose a primary care physician and do not require referrals.

With more flexibility than the Spira Care option, and a lower deductible than the HSA option, this plan option has the highest premiums and annual out-of-pocket maximum for employees.



Medical Plan Comparison

Plan Provision	Spira Care EPO		\$3,400 Deductible HSA		\$1,000 Traditional PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
*Deductible Individual/Family	\$3,500 / \$7,000	Not Covered	\$3,400 / \$6,800		\$1,000 / \$3,000	
Coinsurance	0%	Not Covered	0%	20%	20%	50%
*Maximum Out of Pocket Individual/Family (Includes all Copays, Deductible & Coinsurance)	\$3,500 / \$7,000	Not Covered	\$3,400 / \$6,800	\$6,800 / \$13,600	\$4,000 / \$8,000	\$8,000 / \$16,000
Preventive Care	No Cost	Not Covered	No Cost	Deductible + 20%	No Cost	Deductible + 50%
Office Visit: Primary or Specialist	Spira Care: No Cost Other: Deductible	Not Covered	Deductible	Deductible + 20%	\$30 Copay	Deductible + 50%
Urgent Care	Deductible	Not Covered	Deductible	Deductible + 20%	\$30 Copay	Deductible + 50%
Blue KC Virtual Care	No Cost	Not Covered	No Cost	Not Covered	No Cost	Not Covered
Hospital: Inpatient or Outpatient	Deductible	Not Covered	Deductible	Deductible + 20%	Deductible + 20%	Deductible + 50%
Emergency Room	Deductible	Not Covered	Deductible		\$100 Copay + Deductible + 20%	
Retail Prescription Tiers 1 / 2 / 3 / 4	\$15 / \$50 / Deductible	Not Covered	Deductible	Deductible + 50%	\$15 / \$70 / \$110 / \$200	Copay + 50%
Mail Order Prescription Tier 1 / 2 / 3	\$15 / \$125 / Deductible	Not Covered	Deductible	Deductible + 50%	\$37.50 / \$175 / \$275	Copay + 50%

*Using In-Network providers and facilities saves you significant out-of-pocket expenses. Finding in-network providers and facilities is fast and simple. See the contacts page of this Guide for carrier contacts.

Virtual Care

Virtual care provides access to licensed doctors and behavioral health providers online anytime for common medical issues and mental health support. Consider a virtual visit for convenient consultations from home or on the go, and support during evenings, weekends, or when your doctor isn't available.

Common Conditions Treated

- Common Medical Issues: COVID-19, pink eye, minor fevers, colds, sore throat, sinus pain, asthma, rashes, nausea, minor burns, and sprains
- Behavioral health: anxiety, depression, PTSD, panic attacks, OCD, Bipolar disorder, grief, and more

How to Start

- Download the MyBlueKC app or visit MyBlueKC.com.
- Choose a doctor from available options.
- Create an account with your Blue KC member ID.

Prescriptions Savings with RXSS

Rx Savings Solutions (RxSS) is a free tool for members and dependents to find prescription savings. RxSS pharmacists work with your doctor or pharmacist to reduce costs safely. For support, call 1-800-268-4476.

How RxSS Helps You Save

- Explore Options: Compare treatment options and costs.
- Transparent Pricing: See medication costs, coverage, and deductible impact.
- Easy Access: Request lower-cost prescriptions anytime, even at the doctor's office.
- Expert Assistance: RxSS staff coordinate with your doctor for safe savings.

Start Saving with Rx Savings Solutions

- Log in at MyBlueKC.com.
- Go to Plan Benefits > Pharmacy.
- Select "Shop & Save with Rx Savings Solutions" or visit MyRxSS.com/BlueKC.

Save & Earn with SmartShopper

Medical costs vary widely by facility. Blue KC's SmartShopper helps you find in-network providers and healthcare services with lower-cost options and earn cash rewards for choosing cost-effective care.

Accessible on MyBlueKC.com, SmartShopper lets you view a range of in-network providers and facilities and compare prices side by side. This program supports Blue KC's commitment to cost transparency and savings by passing a portion of the savings back to you in the form of cash rewards.

How to Use SmartShopper

- Log into MyBlueKC.com and go to Find Care > Find Doctors, Specialists & Hospitals.
- Click the SmartShopper rewards tile to compare costs for your procedure.
- Choose a reward-eligible provider and receive care. Once your claim is paid, you'll receive a reward check.
- For support, call Blue KC Customer Service at the number on your member ID card.

Dental Insurance

Regular dental visits protect both your smile and health. Gum disease links to other health issues, and dentists can spot signs of diseases like cancer, diabetes, and heart disease. The Company offers two dental plans through Principal. Find in-network dentists at principal.com/dentist.

Base Plan	In-Network	Out-of-Network
Calendar Year Deductible	\$50 / covered person \$150 / family	
Annual Plan Maximum	\$1,000 / covered person	
Diagnostic and Preventive (exams, cleanings, x-rays, sealants, etc.)	100%	100%
Basic Services (such as fillings, emergency exams, etc.)	80%	80%
Major Services	50%	50%
Orthodontia	Not Covered	Not Covered
Rollover Benefit	Provided. Allows for a portion of unused dollars to roll over to next year's maximum benefit. To qualify, must have had dental service in the calendar year and use less than \$1,000.	
Buy-Up Plan	In-Network	Out-of-Network
Calendar Year Deductible	\$50 / covered person \$150 / family	
Annual Plan Maximum	\$1,500 / covered person	
Diagnostic and Preventive (exams, cleanings, x-rays, sealants, etc.)	100%	100%
Basic Services (such as fillings, emergency exams, etc.)	80%	80%
Major Services	50%	50%
Orthodontic Services	50% up to a \$1,500 Lifetime Maximum per eligible dependent	50% up to a \$1,500 Lifetime Maximum per eligible dependent
Rollover Benefit	Provided. Allows for a portion of unused dollars to roll over to next year's maximum benefit. To qualify, must have had dental service in the calendar year and use less than \$1,000.	

*Out-of-Network providers can bill you for costs not covered by the plan, which may lead to higher out-of-pocket expenses.

Vision Insurance

Regular eye exams can help detect conditions like diabetes and glaucoma. For the best coverage and lowest out-of-pocket costs, use in-network providers. Visit principal.com and select “Locate a Provider” to find one.

Benefit	In-Network	Out-of-Network Allowance
Eye Exam Copay Frequency Allowance	\$10 Copay Every 12 Months 100%	N/A Every 12 Months Up to \$45
Prescription Glasses Copay Frequency Single Allowance Bifocal Allowance Trifocal Allowance Lenticular	\$25 Copay Every 12 Months 100% 100% 100% 100%	N/A Every 12 Months Up to \$30 Up to \$50 Up to \$65 Up to \$100
Frames Frequency Allowance	Every 12 Months \$130 + 20% off remaining amount	Every 12 Months Up to \$70
Contact Lenses Lens Fitting Copay Elective Medically Necessary	Up to \$60 Copay \$130 Allowance Covered in Full after \$25 Copay	N/A Up to \$105 Up to \$210

Laser Vision Correction

Employees, spouses, and dependents can save \$800 with LASIK providers (LASIKPlus, TLC Laser Eye Centers, or The LASIK Vision Institute) or receive 15% off standard or 5% off promotional pricing through the National LASIK Network, administered by LCA Vision.

Visit Principal.com to access vision benefits, find providers, view eligibility, download forms, and more. Register online to get started!



Group Life & AD&D

The Company provides Life and AD&D insurance through Principal at no cost to you, ensuring your loved ones are supported during life’s most difficult moments.

Group Life provides a lump sum to your beneficiary equal to one time (1x) your annual salary (rounded to the next \$1,000) with a maximum of \$200,000 if you pass away. Coverage reduces by 35% at age 65 and by 50% at age 70.

AD&D provides another layer of benefit to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The amount is equal to your basic life benefit.

Voluntary & Dependent Life & AD&D

Voluntary life and AD&D is additional coverage you can purchase for yourself, spouse, or children. To cover a spouse or child, employee voluntary life coverage is required.

Spouse rates vary by age; child rates are a flat cost regardless of the number covered. Coverage reduces by 35% at age 70 and 55% at age 75. Requests above the guaranteed issue amount, increases, or added coverage beyond the initial offering require a health questionnaire.

Voluntary Life Coverage Level Options	
Employee Voluntary Life / AD&D	\$10,000 increments up to \$500,000 Guaranteed Issue is \$100,000 (under age 70)
Spouse Voluntary Life / AD&D	\$5,000 increments up to \$150,000 Guaranteed Issue is \$30,000 (under age 70)
Child(ren) Voluntary Life / AD&D	\$2,000, \$4,000, or \$10,000 \$100 under six months of age Birth to six months max benefit \$1,000

Monthly Rates for Voluntary Life / AD&D By Age Band										
Adult Age Bands	0-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Adult Rate (per \$1,000)	\$0.131	\$0.140	\$0.184	\$0.266	\$0.383	\$0.592	\$0.900	\$1.229	\$2.226	\$3.622
Dependent Child(ren)	\$2,000 benefit \$0.40/month - \$4,000 benefit \$0.80/month - \$10,000 benefit \$2.00/month									

Amount of Coverage
(for employee, increments of \$10,000 up to \$500,000)

/

\$1,000

x

Age Rate
(ex: 36-year-old pays \$0.184)

=

Premium per Month

Short-Term Disability (STD)

If you're unable to work due to a qualified short-term disability, including maternity leave, the Company provides STD coverage through Principal at no cost to you. The plan replaces 70% of your regular salary, up to \$2,500 per week, for up to 11 weeks after a 14-day elimination period. You may use PTO during this waiting period to cover lost earnings.

Work-related illnesses or injuries are not covered under STD, as they fall under workers' compensation insurance.

Long-Term Disability (LTD)

A long-term disability can significantly affect your income. To help protect you, the Company provides LTD coverage through Principal at no cost to you. The plan replaces 66.67% of your regular salary, up to \$7,500 per month, beginning after a 90-day elimination period.

Benefits are paid for up to two years if you cannot work in your own occupation and continue thereafter if you are unable to work in any occupation based on your training, experience, and education. Coverage continues until your Social Security Normal Retirement Age if you are under 65; employees age 65 or older have a limited benefit duration.

- Age 65-67 – 24 months
- Age 68-69 – 18 months
- Age 70-71 – 15 months
- Age 72 and over – 12 months

How to File Disability Claim

Disability claims must be completed online or on paper. If you need assistance filing a disability claim, please see Human Resources or call the Principal Claims Hotline at (800) 245-1522, weekdays, 7:00am to 5:00pm, CST for assistance. Refer to your member ID (social security number) and your plan number: 1103065



Employee Assistance Program (EAP)

Lucet

Employee
Assistance Program



Personalized care and resources, *when you need them.*

Whether its planning for your financial future or beginning to seek mental health resources, your Employee Assistance Program (EAP) is here to help. Available to you and your household members, Lucet's EAP is your first step to resources, counseling and so much more to support your wellbeing.

We're here to help

Stress, relationships, work and money. These are the most common reasons people reach out to EAP every year. No matter what issues you're facing, the resources you access are confidential so feel safe knowing you can begin addressing any of your personal challenges today.

EAP Services & Resources

Help for every day life

-  **Counseling**
Call us or go online to access no-cost sessions with a provider.
-  **Legal & Financial**
Navigating finances and the legal system with a no-cost 30-minute telephonic consultation per issue.
-  **Work/Life**
Referrals and resources for family, career, caregiving, health and wellness needs.
-  **Coaching**
Sessions with a life coach designed to promote self-awareness and clarify goals.



◆ Your well-being is our priority.

Lucet EAP provides confidential support, counseling services and resources to help you overcome life challenges and live a happy, balanced life.

Call 800-624-5544 | Visit eap.lucethealth.com

Your company code: **Clarkson**

6 counseling/coaching sessions, per topic, per year.



Scan to learn more at
eap.lucethealth.com

Retirement / 401(k)

The Company offers a 401(k) plan through Empower to help you save for retirement. This summary highlights key provisions. Please refer to Empower's official plan documents for full details.

Eligibility

New hires with regular employment status become eligible to participate on the first day of the month following 2 months of employment. You must be 21 years of age or older to participate.

Plan Options & Company Match

You may contribute on a pre-tax or Roth (after-tax) basis—or a combination of both—up to IRS annual limits. Contributions must be in whole percentages and will be deducted from eligible earnings from your checks.

The Company matches 50% of the first 6% you contribute each pay period. The company match vests over three years.

2026 401(k) Contribution Limits

Contribution limits are set by the IRS annually and generally announced in late October or early November for the following calendar year. For 2026, the 401(k) contribution limits are:

- Under age 50: \$24,500
- Age 50+: +\$8,000 catch-up (total \$32,500)
- Ages 60–63: +\$11,250 catch-up (total \$35,750)

Automatic Enrollment & Contribution Increases

You'll be automatically enrolled at a 6% pre-tax contribution unless you elect otherwise. For auto-enrolled participants, contributions automatically increase 1% each January 1, up to 15%. You may change your contribution or opt out anytime at empowermyretirement.com or 800-338-4015.



New: Secure 2.0 Act Roth Catch-Up Provision

Employees age 50+ who earned \$150,000+ (indexed) in FICA-taxable wages with the Company in the prior year must make catch-up contributions as Roth (after-tax). If applicable, the system will automatically shift your catch-up contributions to Roth once you reach the regular 401(k) limit. Participants who earned less than \$150,000 (indexed) in FICA-taxable wages with the Company in the prior year may continue catch-up contributions as pre-tax or Roth.

Regular 401(k) contributions are not affected and may remain pre-tax or Roth for all employees, regardless of income.

Paid Time Off (PTO)

Regular employees on active status accrue paid time off (“PTO”) based upon their years of active service. Employees begin to accrue PTO upon date of hire as “Active Service” commences with an employee’s first day of work and continues thereafter unless broken by a leave of absence, or termination of employment. Employees on any leave of absence including but not limited to FMLA, Short-Term Disability or Long-Term Disability, do not accrue PTO. Temporary and part-time employees will not accrue PTO except where required by law.

Employees may use PTO for any reason, including vacation, personal commitments, emergencies, family care, medical and dental appointments, as well as any reason for which paid sick leave is allowed under state or local law. For scheduling purposes, all PTO requests must be submitted via UKG in as far advance as possible. If the need for PTO is foreseeable, the request should be submitted at least two (2) weeks in advance. If taken for a reason protected by state or local paid sick leave law, the Company may request supporting documentation. In circumstances allowed by law, supervisors/managers reserve the right to decline a PTO request. PTO may be taken in increments of one (1) hour or more.

PTO rolls over from year to year and can accrue up to a maximum balance equivalent to the employee’s total annual accrued hours + 40 hours. Once this maximum balance is reached, the employee will not accrue PTO until some PTO is used allowing for additional accrual up to the maximum.

Except where otherwise stated, employees are required to use available PTO before taking an unpaid leave or having unpaid absences of any kind including, but not limited to, FMLA, Short-Term Disability or Long-Term Disability.

For non-exempt, hourly paid employees, PTO hours do not count the same as regular worked hours and will not be included for weekly overtime calculations. PTO accrues on the following basis:

Years of Active Service	PTO Hours Accrued / Pay Period	PTO Hours Accrued / Year	PTO Days Accrued / Year	PTO Hours Maximum Balance
Hire Date – Year 5	2.308	120	15	160
Beginning of 6th Year – Year 10	3.077	160	20	200
Beginning of 11th Year +	3.847	200	25	240

Employees who terminate employment for any reason will be paid for accrued, unused PTO.



This PTO policy is effective upon the release of this Benefit Guide, on Nov. 10, 2025.

Paid Holidays & Leaves

Paid Holidays

The Company provides one work-day / 8 hours of holiday paid for the following observed holidays:

- New Year's Day (January 1st)
- Memorial Day (Last Monday in May)
- Independence Day (July 4th)
- Labor Day (First Monday in September)
- Thanksgiving Day (4th Thursday in November)
- Day after Thanksgiving
- Christmas Eve (Dec. 24th)
- Christmas Day (Dec. 25th)
- New Year's Eve (Dec 31st)

Holidays falling on weekends are generally observed on the nearest weekday, unless another day is designated by the Company. Holiday schedules will be announced in advance.

Employees are eligible for holiday pay upon hire. Hourly employees who work on a scheduled holiday receive both regular pay and holiday pay. Holiday pay does not count toward weekly overtime hours. Part-time employees working 20+ hours per week receive 4 hours of holiday pay per holiday.

Paid Jury Duty Leave

Employees are encouraged to serve when called for jury duty. The Company will provide full pay for up to 40 hours/5 business days. Notify your supervisor as soon as you receive the court summons and provide a copy. You may be asked for written verification of service. If you are released from jury duty with work time remaining, you are expected to return to work for the rest of your shift.

Paid Bereavement Leave

We understand that a death in your family is devastating. To give employees necessary paid time to attend to family matters, The Company grants paid bereavement leave to employees who experience a death in the family as follows:

- 80 hours / 10 work days for death of employee's spouse or children
- 40 hours / 5 work days for death of employee's mother, father, siblings
- 24 hours / 3 work days for employee's mother-in-law, father-in-law, siblings-in-law, grandparents, or grandchild.

Paid bereavement leave must be approved by the Company. Supervisors and managers may approve additional unpaid bereavement leave to allow an employee more time during their time of need.

Paid Parental Leave

Employees requiring parental leave for the birth or adoption of their own child will be paid 100% of normal hourly wage or salary up to 40 hours / 5 days. Pregnancy disability leave / maternity leave and related pay is covered under the provisions of the FMLA and Short-Term Disability policies. Parental leaves may run concurrently with FMLA, if applicable.

Additional Benefits

Corporate Gym Membership

Regular exercise helps prevent excess weight gain, combats health condition and diseases, improves mood, boosts energy, and promotes better sleep. The Company has partnered with the YMCA to offer employees and their families gym membership benefits at every YMCA location in the nation.

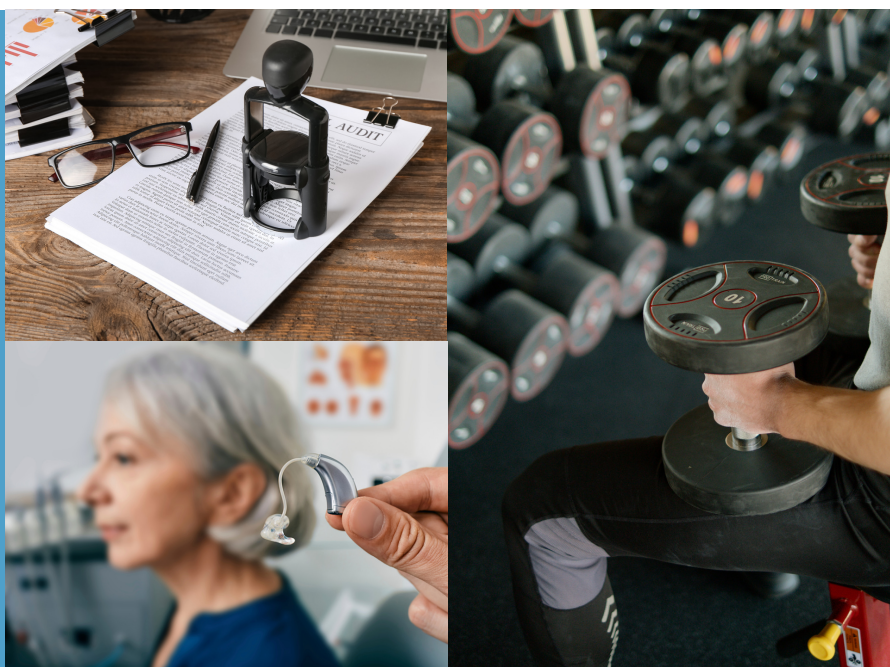
You and all your household members are eligible for this benefit. In addition to enjoying lower rates due to our corporate membership, The Company subsidizes the monthly cost. We can't make working out easy, but we have made it affordable!

Notary Services

The Company is fortunate to have several notary publics on staff who are more than happy to notarize your documents at no charge. If you have a need for notary services, please see Human Resources for more information.

Principal Hearing Aid Program

Protect your hearing health to improve your quality of life. You, your spouse, children, parents and grandparents can get exclusive discounts up to 48% off on hearing aids, including rechargeable and Bluetooth options, with a 60-day trial to ensure your full satisfaction. You can also receive a free hearing consultation at any of their 3,000+ locations nationwide. Visit principal.com/hearingbenefits/ahb or call 877-890-4694 to learn more!



Medical Rates

Blue Cross Blue Shield Medical Plans		
\$3,500 Spira Care	Your Cost Per Month	Your Cost Per Check
Employee Only	\$106.78	\$24.64
Employee + Spouse	\$269.09	\$62.10
Employee + Child(ren)	\$206.09	\$47.56
Family	\$305.38	\$70.47
\$3,400 HSA Base Plan	Your Cost Per Month	Your Cost Per Check
Employee Only	\$125.09	\$28.87
Employee + Spouse	\$315.16	\$72.73
Employee + Child(ren)	\$284.09	\$65.56
Family	\$484.17	\$111.73
\$1,000 PPO Buy-Up Plan	Your Cost Per Month	Your Cost Per Check
Employee Only	\$266.94	\$61.60
Employee + Spouse	\$576.62	\$133.06
Employee + Child(ren)	\$515.37	\$118.93
Family	\$807.10	\$186.25

Dental Rates

Principal Dental Plans		
Base Plan	Your Cost Per Month	Your Cost Per Check
Employee Only	\$5.79	\$1.34
Employee + Spouse	\$38.25	\$8.83
Employee + Child(ren)	\$73.11	\$16.87
Family	\$113.57	\$26.21
Buy-Up Plan	Your Cost Per Month	Your Cost Per Check
Employee Only	\$18.45	\$4.26
Employee + Spouse	\$60.47	\$13.95
Employee + Child(ren)	\$88.40	\$20.40
Family	\$138.44	\$31.95

Vision Rates

Principal Voluntary Vision Plan		
Employee Only	\$7.09	\$1.64
Employee + Spouse	\$14.18	\$3.27
Employee + Child(ren)	\$14.32	\$3.30
Family	\$22.59	\$5.21

YMCA Rates

YMCA Corporate Gym Membership		
Employee Only	\$29.00	\$6.69
Employee + Dependent(s)	\$58.00	\$13.38

Voluntary Life & AD&D Rates

Principal Voluntary Life & AD&D Insurance
Rates vary by age and amount you elect. Please see detail page.

Company Provided Benefits

Principal Group Life & AD&D
Paid 100% by the Company.
Principal Short-Term and Long-Term Disability Insurance
Paid 100% by the Company.
Lucet Employee Assistance Program (EAP)
Paid 100% by the Company.

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Global Earthwork & Underground Health & Welfare Plan

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for the 2026 Plan Year



Notice of HIPAA Special Enrollment Rights

If you chose to decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

You may also be able to enroll in this plan if coverage is lost under a Medicaid plan or CHIP, or due to a determination of eligibility for a

premium assistance subsidy under Medicaid or CHIP. In these events you must request enrollment within 60 days of the date of a determination of eligibility for premium assistance or the date the Medicaid or CHIP coverage ends.

Additionally, 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.

Please note that in such cases enrollment is not automatic, and therefore following the enrollment process in its entirety is required, even if it does not change your election tier. So for example, you must formally enroll your newborn child onto the plan within 30 days

of the date of birth *even if you already have family coverage and your premiums would not change as a result*. Failing to enroll a dependent would result in that dependent not having coverage even though the coverage for the rest of the family would continue.

Finally, please be advised that this plan reserves the right to require a written reason for declining the offer of coverage. When an enrollment/waiver form is provided for this purpose, a signed and dated letter waiving the coverage and specifying the specific reason for declining the coverage may be accepted by the Plan Administrators.

To request special enrollment or obtain more information, contact Tara McKinney at (913) 433-3199 or t.mckinney@geukc.com.

NOTICE: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, please see the Notice of Creditable Coverage on Page 7 for important information!

All questions should be directed to:

Tara McKinney
(913) 433-3199
t.mckinney@geukc.com

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Newborns' and Mothers' Health Protection Act Notice

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

Note that more generous lengths of stay may apply under certain state laws, when applicable. In such cases, please refer to plan documents for a description of these richer guidelines.

Women's Health and Cancer Rights Act Notice

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

- All stages of reconstruction of the breast on which the mastectomy was performed;

- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Any benefits payable will be subject to the same deductibles, coinsurance and other provisions applicable to other surgical and medical benefits provided under the plan. Please see your Summary of Benefits and Coverage (SBC) or other plan materials for your medical and surgical deductible and coinsurance information.

To request more information on WHCRA benefits, please contact Tara McKinney at (913) 433-3199 or t.mckinney@geukc.com.

General Notice of COBRA Continuation Coverage Rights

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about

your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

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

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

- Your hours of employment are reduced, or

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- 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:

- Death of your spouse;
- 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:

- Death of parent-employee;
- 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 the person listed at the front of this booklet.

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.

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, or other

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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 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 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 can be directed to Tara McKinney at (913) 433-3199 or t.mckinney@geukc.com. 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 subject to ERISA, 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.

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.

Termination of Coverage for Cause

Please be advised that our Plan reserves the right to terminate coverage for cause, when applicable and as permitted by the Plan's rules and/or administrative guidelines.

Presumption of COBRA and USERRA Concurrent Election Disclosure

Please note that any continuation rights under COBRA and the Uniformed Services Employment and Reemployment Rights Act (USERRA), when applicable, are similar but not identical. When both are available, the election for continuation

coverage that you, the employee, make pursuant to COBRA will also be considered your election under USERRA for you and your covered dependents. Thus, USERRA will apply with respect to the COBRA continuation coverage elected by you and any COBRA continuation coverage elected by your covered dependents. Continuation coverage under both statutes will run concurrently (at the same time), so that, for example, when your (or your covered dependent's) first 18 months of concurrent COBRA and USERRA continuation coverage ends, you (or your covered dependent) will have up to an additional six months of continuation coverage under USERRA.

For periods of time in which you (or your covered dependents) have continuation coverage pursuant to both COBRA and USERRA, the law that provides the greater benefit will apply. The administrative policies and procedures described in our COBRA Election Notice (for example, the procedures for how to elect COBRA coverage and for paying premiums for COBRA coverage) also apply to USERRA coverage, unless compliance with the COBRA procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you have continuation rights under both laws, instead of making the combined COBRA and USERRA election described above you may make an election under only COBRA or, alternatively, you may make an election under only USERRA. For information about how to make a USERRA-only or COBRA-only election please contact Tara McKinney at (913) 433-3199 or t.mckinney@geukc.com.

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YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ★ you ensure that your employer receives advance written or verbal notice of your service;
- ★ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ★ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ★ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to be Free from Discrimination and Retaliation

If you:

- ★ are a past or present member of the uniformed service;
- ★ have applied for membership in the uniformed service; or

- ★ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ★ initial employment;
- ★ reemployment;
- ★ retention in employment;
- ★ promotion; or
- ★ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

- ★ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ★ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

- ★ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ★ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at

<http://www.dol.gov/vets>. An interactive online USERRA Advisor can be viewed at <http://www.dol.gov/elaws/userra.htm>.

- ★ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ★ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed at <http://www.dol.gov/vets/programs/userra/poster/htm>. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

Taxable Fringe Benefit Reminder for Non-Tax Dependents

Although employers can generally exclude certain fringe benefits from an employee's taxable income, per IRS rules this tax-favored treatment applies only to benefits for employees, their legal spouses, Code §105b tax dependents, and children under 27 at the end of the tax year.

If and when benefits such as health, dental, and vision are provided to individuals who are not tax dependents, **the Fair Market Value of such benefits will be reported as taxable income to the employee** or other recipient in accordance with Federal and State Law, as applicable. **It is our administrative practice to assume these individuals are not tax**

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dependents unless the employee informs us otherwise, in writing, and provides us with any requested evidence or attestation as our administrative guidelines require at the time.

Finally, be advised that individuals who are not Code §105(b) tax dependents are not eligible for reimbursement using funds from an HSA trust (bank account), even if eligible

for reimbursement by the underlying High Deductible Health Plan. Please refer to plan materials for details on eligible individuals for each respective benefit program.

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NOTE: THE PRIMARY INSURED IS RESPONSIBLE FOR PROVIDING THIS NOTICE TO ALL MEDICARE ELIGIBLE FAMILY MEMBERS (or those about to become Medicare Eligible)!

Notice of Creditable Coverage for the 2026 Plan Year

We have determined that the prescription drug coverage provided under the Global Earthwork & Underground Health & Welfare Plan is expected to pay out, on average, the same or more than what the standard Medicare prescription drug coverage will pay. This is known as “creditable coverage” as defined by the Medicare Modernization Act (MMA).

Why This is Important

When someone first becomes eligible to enroll in a government-sponsored Medicare “Part D” prescription drug plan, enrollment is considered timely if completed by the end of his or her “Initial Enrollment Period” which ends 3 months after the month in which he or she turned age 65.

Unfortunately, if you choose not to enroll in Medicare Part D during your Initial Enrollment Period, *when you finally do enroll you may be subject to a late enrollment penalty* added to your monthly Medicare Part D premium. Specifically, the extra cost, if any, increases *based on the number of full, uncovered months* during which you went without either Medicare Part D or else without “creditable” prescription drug coverage from another source (such as ours).

It is important for those eligible for both Medicare and our group health plan to look ahead and weigh the costs and benefits of the various options on a regular, if not annual, basis. Based on individual facts and circumstances some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, please note that benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would *reduce payment* in order to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

Eligible individuals can enroll in a Medicare Part D prescription drug plan during Medicare’s “Annual Coordinated Election Period” (a.k.a. “Open Enrollment Period”) running from Oct. 15 through Dec. 7 of each year, as well during what is known as a “Medicare Special Enrollment Period” (which is triggered by certain qualifying events, including the loss of creditable group prescription drug coverage). **Those who miss these opportunities are generally unable to enroll in a Medicare Part D plan until another enrollment period becomes available.** Finally, please be cautioned that even if you elect our coverage, you could be subject to a payment of higher Part D premiums if you subsequently experience a break in coverage of 63 continuous days or longer before enrolling in the Medicare Part D plan. Carefully coordinating your transition between plans is therefore essential.

If you are unsure as to whether or when you will become eligible for Medicare, or if you have questions about how to get help to pay for it, please call the Social Security Administration at (800) 772-1213 or visit [socialsecurity.gov](https://www.socialsecurity.gov). Specific questions about our prescription drug coverage should be directed to the customer service number on your ID card, if enrolled, or to Tara McKinney at (913) 433-3199 or t.mckinney@geukc.com.

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



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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any

of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

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If you live in one of the following states, you may be eligible for assistance from Medicaid in paying for your employer health plan premiums. The following list of states is current as of Jul. 31, 2025. Contact your State for more information on eligibility –

ALABAMA | Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA | Medicaid

The AK Health Insurance Premium Payment Program

Website: <http://myakhipp.com/>

Phone: 1-866-251-4861

Email:

CustomerService@MyAKHIPP.com

Medicaid Eligibility:

<https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS | Medicaid

Website: <http://myarhipp.com/>

Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA | Medicaid

Health Insurance Premium Payment (HIPP) Program Website:

<http://dhcs.ca.gov/hipp>

Phone: 916-445-8322

Fax: 916-440-5676

Email: hipp@dhcs.ca.gov

COLORADO | Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:

<https://www.healthfirstcolorado.com/>

Health First Colorado Member Contact Center: 1-800-221-3943/ State

Relay 711

CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>

CHP+ Customer Service: 1-800-359-1991/ State Relay 711

Health Insurance Buy-In Program

(HIBI): <https://www.mycohibi.com/>

HIBI Customer Service: 1-855-692-6442

FLORIDA | Medicaid

Website:

<https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>

Phone: 1-877-357-3268

GEORGIA | Medicaid

GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>

Phone: 678-564-1162, Press 1

GA CHIPRA Website:

<https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>

Phone: 678-564-1162, Press 2

INDIANA | Medicaid

Website: <https://www.in.gov/medicaid/> or <http://www.in.gov/fssa/dfr/>

Family and Social Services Administration

Phone: 1-800-403-0864, Member Services Phone: 1-800-457-4584

IOWA – Medicaid & CHIP (Hawki)

Medicaid Website:

<https://hhs.iowa.gov/programs/welcome-iowa-medicaid>

Medicaid Phone: 1-800-338-8366

Hawki Website:

<https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki>

Hawki Phone: 1-800-257-8563

HIPP Website:

<https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp>

HIPP Phone: 1-888-346-9562

KANSAS | Medicaid

Website: <https://www.kan-care.ks.gov/>

Phone: 1-800-792-4884

HIPAA Phone: 1-800-967-4660

KENTUCKY | Medicaid

Kentucky Integrated Health Insurance

Premium Payment Program (KI-HIPP)

Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>

Phone: 1-855-459-6328

Email: KIHIPPPROGRAM@ky.gov

KCHIP Website: <https://kynect.ky.gov>

Phone: 1-877-524-4718

KENTUCKY | Medicaid (continued)

Kentucky Medicaid Website:

<https://chfs.ky.gov/agencies/dms>

LOUISIANA | Medicaid

Website: www.medicaid.la.gov or

www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid

hotline) or 1-855-618-5488 (LaHIPP)

MAINE | Medicaid

Enrollment Website:

https://www.mymaineconnection.gov/benefits/s/?language=en_US

Phone: 1-800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium

Webpage:

<https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 1-800-977-6740

TTY: Maine relay 711

MASSACHUSETTS | Medicaid & CHIP

Website:

<https://www.mass.gov/masshealth/pa>

Phone: 1-800-862-4840 TTY: 711

Email:

masspremassistance@accenture.com

MINNESOTA | Medicaid

Website: <https://mn.gov/dhs/health-care-coverage/>

Phone: 1-800-657-3672

MISSOURI | Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 573-751-2005

MONTANA | Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084

Email: HHSHIPPPROGRAM@mt.gov

NEBRASKA | Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

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NEVADA | Medicaid

Medicaid Website:
<https://dhcfp.nv.gov>
 Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE | Medicaid

Website:
<https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
 Phone: 603-271-5218
 Toll free number for the HIPPA program: 1-800-852-3345, ext. 15218
 Email: DHHS.ThirdParty-Liabi@dhhs.nh.gov

NEW JERSEY | Medicaid & CHIP

Medicaid Website:
<http://www.state.nj.us/human-services/dmahs/clients/medicaid/>
 Phone: 800-356-1561
 CHIP Premium Assistance Phone: 609-631-2392
 CHIP Website: <http://www.njfamilycare.org/index.html>
 CHIP Phone: 1-800-701-0710 (TTY 711)

NEW YORK | Medicaid

Website:
https://www.health.ny.gov/health_care/medicaid/
 Phone: 1-800-541-2831

NORTH CAROLINA | Medicaid

Website: <https://medicaid.ncdhhs.gov/>
 Phone: 919-855-4100

NORTH DAKOTA | Medicaid

Website:
<https://www.hhs.nd.gov/healthcare>
 Phone: 1-844-854-4825

OKLAHOMA | Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
 Phone: 1-888-365-3742

OREGON | Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
 Phone: 1-800-699-9075

PENNSYLVANIA | Medicaid & CHIP

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicare-health-insurance-premium-payment-program-hipp.html>
 Phone: 1-800-692-7462
 CHIP Website:
<https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>
 CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND | Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
 Phone: 855-697-4347, or 401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA | Medicaid

Website: <https://www.scdhhs.gov>
 Phone: 1-888-549-0820

SOUTH DAKOTA | Medicaid

Website: <http://dss.sd.gov>
 Phone: 1-888-828-0059

TEXAS | Medicaid

Website:
<https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>
 Phone: 1-800-440-0493

UTAH | Medicaid & CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website:
<https://medicaid.utah.gov/>
 Email: upp@utah.gov
 Phone: 1-888-222-2542
 Adult Expansion Website:
<https://medicaid.utah.gov/expansion/>
 Utah Medicaid Buyout Program Website: <https://medicaid.utah.gov/buyout-program/>

UTAH | Medicaid & CHIP (continued)

CHIP Website:
<http://health.utah.gov/chip>

VERMONT | Medicaid

Website: <https://dvha.vermont.gov/members/medicaid/hipp-program>
 Phone: 1-800-250-8427

VIRGINIA | Medicaid & CHIP

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>
<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>
 Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON | Medicaid

Website: <https://www.hca.wa.gov/>
 Phone: 1-800-562-3022

WEST VIRGINIA | Medicaid and CHIP

Website: <https://dhhr.wv.gov.bms/http://mywvhipp.com/>
 Medicaid Phone: 304-558-1700
 CHIP Toll-free phone: 1-855-MyWVHIPPA (1-855-699-8447)

WISCONSIN | Medicaid & CHIP

Website:
<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
 Phone: 1-800-362-3002

WYOMING | Medicaid

Website:
<https://health.wyo.gov/healthcare-fin/medicaid/programs-and-eligibility/>
 Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since Jul. 31, 2025, 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

Annual Notices Continued...

Marketplace (Exchange) Notice – Your ACA Coverage Options

To assist you as you evaluate options for you and your family, this notice provides some basic information about the ACA Health Insurance Marketplace (the “exchange”) and employment based health coverage offered.

What is the Government-run Health Insurance Marketplace (exchange)?

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 tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage occurs on an annual basis, and Special enrollment Periods are available throughout the year to those with a qualifying life event such as marriage, divorce, birth or adoption of a child, loss of a job and other events.

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 and a reduction in plan cost-sharing if your employer a) does not offer coverage to you at all or b) does not offer coverage that meets certain standards. Specifically, if your cost for SELF-ONLY coverage on a plan offered to you by your employer is more than 9.5% of your household income for the year (plus all applicable adjustments for inflation), OR if the coverage your employer provides does not meet the “Minimum Value (MV) Standard” set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: There may be some disadvantages if you purchase a health plan through the Marketplace instead of accepting coverage offered by your employer. First, current regulations generally prohibit employers from contributing funds toward non-group health premiums. This means that you will lose any employer premium contributions that would have otherwise been payable. Second, the costs paid toward employer-offered health coverage are generally excluded from income for Federal and State income tax purposes. However, payments for coverage through the Marketplace are made on an AFTER-tax basis.

When can I enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts each Nov. 1 and continues through at least Dec. 15. Certain events may also trigger a midyear Special Enrollment Period, such as when getting married, having a baby or adopting a child, or losing eligibility for other health coverage.

How can I get more information?

For more information about your coverage offered by your employer, please check your coverage materials or contact Tara McKinney at (913) 433-3199 or t.mckinney@geukc.com. The Marketplace or a licensed insurance broker can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) to find more information.

¹ An employer-sponsored health plan meets the “Minimum Value (MV) 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 and meets other requirements.

Annual Notices Continued...

Employer-Specific Information

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 Global Earthwork & Underground		4. Employer Identification Number 88-2500563	
5. Employer address 1801 McGee St. Suite 200		6. Employer phone number (913) 433-3199	
7. City Kansas City	8. State MO		9. Zip code 64108
10. Who can we contact about employee health coverage at this job? Tara McKinney			
11. Phone number (if different from above) (913) 433-3199		12. Email address t.mckinney@geukc.com	

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

As your employer, we offer a health plan to:

All employees we deem eligible for health coverage under the plan's eligibility rules. Generally speaking, coverage is offered to full-time employees working at least 30 hour per week, but other criteria may apply based on employment class and other facts and circumstances.

With respect to dependents:

All eligible spouses and dependents under the age of 26, as well as others who meet specified criteria (e.g., those who meet disabled dependent definitions). Please contact the individual listed in Box 10 (above) with any questions.

- ☒ If checked, this coverage meets the minimum value standard and the cost of this coverage is intended to be affordable for most or all full-time employees under one of the §4980H Affordability Safe Harbors.
- ** 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](https://www.healthcare.gov) will guide you through the process. You may need to get information from your employer, about their coverage, in order to find out if you qualify for a tax credit to lower your monthly premiums.