APTIM




# 2025 SUMMARY PLAN DESCRIPTION

## HEALTH & WELFARE BENEFIT PLANS

# Table of Contents



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

# General Information



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

## Introduction

The health and welfare benefits described in this Summary Plan Description (SPD) are provided under the APTIM Health & Welfare Benefit Plan through the following component plans:

- APTIM Medical Plan.
- APTIM Dental Plan
- APTIM Vision Plan
- APTIM Life Insurance Plan.
- APTIM Travel Accident Insurance Plan.
- APTIM Cafeteria Plan.
- APTIM Spending Accounts.
- APTIM Hourly Employees Short-Term Disability Plan.
- Salary Continuation Plan/Short-Term Disability (STD) (Company payroll practice for salaried employees).
- APTIM Long-Term Disability Plan.

For purposes of this section of the SPD, a reference to the "plan" is a reference to the APTIM Health and Welfare Benefit Plan, including the component plans listed above.

**The plan contains an anti-assignment provision. This provision provides that you and your dependents do not have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you or your dependents may expect to receive, contingently or otherwise, under the plan. In addition, benefits under the APTIM Medical Plan may not be assigned, transferred or in any way made over to another party by you or your dependents. Nothing contained in the written description of the APTIM Medical Plan shall be construed to make the plan or the Company liable to any third party to whom you or your dependents may be liable for medical care, treatment, or services.**

## Who is eligible?

### Eligible employees

You are eligible to participate in the plan if you are:

- A regular full-time or regular part-time employee (with a normally scheduled workweek of at least 20 hours);
- Working for APTIM; and
- Paid on a U.S. employee payroll.

If you are on an international assignment but continue to be paid on a U.S. employee payroll, you may be eligible to participate in certain benefits provided by the plan. Contact the APTIM Benefits Marketplace if this applies to you.

You are not eligible to participate in the plan if you are:

- A leased employee.
- A non-resident alien.
- A temporary/contracted, casual employee, co-op, or summer hire.
- An independent contractor or consultant.
- Covered by a collective bargaining agreement which, by its terms, does not include participation in the plan.
- Working outside the U.S. and do not have any U.S. source employment income (you are eligible for travel accident insurance, but not the other benefits outlined in this SPD).
- Not otherwise classified by the Company as a regular full-time or regular part-time employee.
- Residents of Puerto Rico. (Eligible for ancillary benefits and eligible for medical under alternate plan. Call Benefits Marketplace for more information.)
- U.S. Virgin Islands. (Eligible for ancillary benefits and eligible for medical under alternate plan. Call Benefits Marketplace for more information.)

## Eligible dependents

As an eligible employee, you may also cover your eligible dependents under the plan, as follows:

| Is my dependent eligible? | Yes | No |
|---|---|---|
| **Your spouse/domestic partner (DP)** | | |
| Your legally married spouse. Proof of marriage must be provided upon request. | X | |
| Your common-law spouse, opposite-sex domestic partner (DP), or same-sex domestic partner (DP) where legally required. The common-law marriage must occur in a state where it is legally recognized and the opposite-sex or same-sex domestic partnership must occur in a state where recognition is legally required. | X | |
| Your divorced spouse/DP or legally separated spouse/DP (in states that recognize legal separation).<br><br>Please note: Your ex-spouse/DP is not eligible for plan coverage; however, if your divorce decree requires you to provide him or her with health care coverage, he or she may be eligible for COBRA continuation coverage. See the *Benefit Rights* section for details. | | X |
| **Your child(ren)** | | |
| Your dependent natural born children, stepchildren, or legally adopted children up to age 26, including: | | |
| ▪ Children living with you during a period of adoption probation — or when you become legally obligated to support a child, totally or partially, before adoption. | X | |
| ▪ Children related to you by blood or marriage, including a natural born or legally adopted child (or grandchild*) of you or your eligible spouse/DP. | X | |
| ▪ Children for whom you must provide health care coverage under a Qualified Medical Child Support Order (QMCSO). | X | |
| ▪ Your adult married children. | X | |
| ▪ Your adult children who are eligible for other group health plan coverage. | X | |
| Your dependent children age 26 or older who are disabled or become disabled while covered under the plan.<br>▪ An application for continued coverage must be made before coverage would otherwise end for your disabled child.<br>▪ A child is considered "disabled" if, due to an accidental injury or sickness, he or she is not capable of self-sustaining employment or not able to do all the normal tasks for his or her age and family status.<br><br>The Medical Plan administrator determines disability for eligibility purposes, and you may be required to provide periodic proof of continued disability. | X | |
| Your adult child's spouse/DP or dependent children. | | X |

* *For dependent child life insurance only: For a grandchild to be covered, you or your eligible spouse/DP must be the court-appointed legal guardian of the grandchild, and that grandchild must be living with you and be financially dependent on you.*

Regardless of the information on the previous page, your dependent is **not** eligible if he or she is:

- Over age 26, unless disabled or becomes disabled while covered under the plan.
- On active duty in any military service of any country.
- Not a U.S. citizen or resident alien, unless qualified to work in the U.S. under a valid work visa.
- Already covered under the plan as an employee, retiree, COBRA participant, or dependent.
- A parent, sibling, grandparent, niece, nephew, or any other relation to you other than a spouse/DP or child as specifically described in the table on the previous page. **Note:** These other dependents may qualify for coverage under the flexible spending accounts, but only if they meet the requirements described in the *Flexible Spending Accounts* section starting on page F-1.
- Your domestic partner.

If your dependent ceases to be eligible for any reason, you must notify the APTIM Benefits Marketplace **within 31 days** (see "Qualifying life events" on page A-11 for more information).

**When your child turns age 26**

When your dependent child is no longer eligible for coverage under the plan because he or she turns age 26, the child is automatically removed from all plans effective the end of the month in which they turn 26. Your ineligible child may be able to continue medical (including prescription drug benefits), EAP, dental and vision coverage through COBRA — see the *Benefit Rights* section for details.

You will need to contact the APTIM Benefits Marketplace to drop dependent life coverage when your child turns age 26.

### *Dependent eligibility audit*

If you are enrolling dependents for coverage during your new hire enrollment, annual benefits open enrollment, or via a qualifying life event, you will be required to complete the dependent eligibility audit to verify that your dependents are benefits-eligible according to current plan rules.

Upon enrollment, your eligible dependents will be added to your coverage. Shortly thereafter, you will receive a letter in the mail (and email if you have an email address on file) explaining the audit process. You **must** provide the requested documentation within 52 days from the date you enroll (see "New hire enrollment" on page A-6) or your dependents' coverage will be dropped with no option to elect COBRA continuation coverage. During that 52-day period, you will receive follow-up letters and emails (if an email address is on file) reminding you of the requested documentation.

### *If both you and your dependent work for the Company*

You and/or your dependent cannot be covered as both an employee and a dependent under the plan. If you and your spouse/DP or you and your child both work for the Company:

- You can elect to be covered either as an employee or a dependent of the other employee, but not both.
- Any dependent child whose parents both work for the Company can be covered as a dependent under only one parent.

### *If you enroll an ineligible dependent*

If you enroll a dependent who does not meet the eligibility requirements or if you fail to cancel coverage for an ineligible dependent, such action constitutes fraud or an intentional misrepresentation of material fact and:

- The ineligible individual's coverage will be terminated.
- You may be required to reimburse the plan for all benefits, reimbursements, fees and claims paid by the plan to, or on behalf of, the ineligible individual.
- Your coverage under the plan may be terminated.
- You will not be reimbursed or refunded for any premiums paid for the ineligible individual.
- You may be subject to disciplinary action — up to and including termination of employment.
- Your ineligible dependent will lose the right to elect continuation coverage under COBRA (see the *Benefit Rights* section for more information).

### *Affordable Care Act medical coverage*

In the case of a group health plan, if coverage is not funded by an insurer, Health Maintenance Organization (HMO) or Dental Maintenance Organization (DMO), an individual shall not be entitled to coverage under the plan if the individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud, or the individual makes an intentional misrepresentation of material fact, in connection with the enrollment of the individual in the plan.

## Before You Enroll

### Start with the Make It Yours website

Before you enroll, you'll have access to the Make it Yours pre-enrollment healthcare education website where you have access to great tools and resources.

Go to the Make it Yours website at https://aptim.makeityoursource.com to:

- Watch videos.
- Review plan details.
- See comparison charts.
- Get answers — browse Frequently Asked Questions (FAQs).
- Prepare for enrollment.

### Check Out Health Insurance Carrier Preview Sites

Before you pick a carrier and enroll, be sure to compare key information for each carrier you're considering.

Go to the Your Carrier Connection section of the Make it Yours website at https://aptim.makeityoursource.com/your-carrier-connection to:

- Learn more about each carrier.
- See whether your doctors are in the network.
- Learn how your prescription drugs are covered.
- Read up on condition management and wellness programs, such as a 24-hour nurse line or healthy lifestyle coaching.

## How do I enroll?

### New hire enrollment

As a newly hired salaried employee, you must enroll in benefits **within 31 days of becoming eligible for benefits**.

As a newly hired hourly/craft employee, you must enroll in benefits **within 31 days of becoming eligible for benefits**. Hourly/craft employees become eligible the first of the month following 30 days from date of hire.

See "Eligible employees" starting on page A-2 to see if you are eligible for coverage. If eligible, you have three ways to enroll — online, phone, or mobile app.

#### *Online*

Log on to the APTIM Benefits Marketplace website at digital.alight.com/aptim and click **New User** to register. If you do not have an APTIM email you will need to add a personal email to your profile in order to receive communications and reset username and passwords. Once you have completed registration click **Enroll Now**. You will be guided through the enrollment process and have access to helpful resources along the way. Once you've enrolled, your follow-ups will appear on a confirmation page.

#### *Phone*

Call the APTIM Benefits Marketplace at 1-833-476-2342. Representatives are available Monday through Friday from 8 a.m. to 5 p.m. CT.

**Important — New Hires During or After Open Enrollment**

For new employees hired during or after Benefits Open Enrollment, please note that you must enroll in both the current 2025 benefits and next year's 2026 benefits. See "Annual benefits open enrollment" starting on page A-7 for more information.

#### *Mobile App*

Enroll using the Alight Mobile app. To download the app, visit the Apple App Store or Google Play and search "Alight Mobile." Prior to using the app, visit digital.alight.com/aptim on your desktop computer to register and add a phone number to your profile.

#### *QR Code*

Use the QR code to have 24/7 access to the APTIM Benefits Marketplace where you can learn about your options and enroll in your health and welfare benefits.

If you do not enroll within 31 days of becoming eligible, you cannot enroll in benefits until the next annual benefits open enrollment period unless you have a qualifying life event, such as getting married or having a baby (see "When can I change coverage?" on page A-10).

Generally, the medical, dental, vision and flexible spending account (FSA) benefits you elect as a new hire will remain in effect through the end of the calendar year, unless you have a qualifying life event.

✓ **Enrollment Confirmation**

For your health and welfare benefits, if you enroll online, be sure to keep a copy of the confirmation for your records. If you have an email address on file, you will receive an email confirming that your health and welfare elections have been received. If you do not have an email address on file, you will receive a hard copy of your elections via mail at your address of record.

For your financial plans, you will receive a confirmation at your address of record.

## Annual benefits open enrollment

The Company has a benefits open enrollment period each year with changes effective January 1 of the following year. As long as you remain eligible, your annual benefits open enrollment elections generally remain in effect for the entire calendar year unless you have a qualifying life event (see "Qualifying life events" on page A-11).

If you take no action during annual benefits open enrollment, you will be automatically enrolled in the same benefit plans, at the same coverage level, as long as you remain eligible for those benefits — with the exception of your participation in Flexible Spending Accounts (FSAs) or Health Savings Account (HSA). Your Health Care FSA, Limited Purpose FSA, and/or Dependent Care FSA elections do **not** carry forward and must be re-elected each year. If you are making contributions to a Health Savings Account (HSA), your annual HSA contribution amount will not roll over, but you can change your annual contribution anytime through out the year.

During annual benefits open enrollment:

| If you are enrolled in the following benefit plans… | You are required to make elections during annual benefits open enrollment… |
|---|---|
| ▪ **Medical**<br>▪ **Dental**<br>▪ **Vision**<br>▪ **Short-term disability (STD) *(hourly/craft employees only)***<br>▪ **STD buy-up option *(salaried employees only)***<br>▪ **Long-term disability (LTD) *(hourly/craft employees only)***<br>▪ **LTD buy-up option *(salaried employees only)***<br>▪ **Optional life and Accidental Death & Dismemberment (AD&D) Insurance**<br>▪ **Accident insurance**<br>▪ **Hospital indemnity insurance**<br>▪ **Identity theft protection**<br>▪ **Commuter benefit**<br>▪ **Critical illness insurance** | ▪ Begin coverage (if you don't currently have coverage)<br>▪ Waive coverage<br>▪ Change to a different plan option<br>▪ Add a new dependent or remove an existing dependent from coverage<br>*Please note that the Salary Continuation/STD and LTD Plans are core benefits paid by the company and enrollment is automatic for salaried employees.* |
| ▪ **Health Care FSA or Limited Purpose FSA**<br>▪ **Dependent Care FSA** | ▪ Elect an annual contribution amount **(this does not roll over from year to year — you must make an active election to contribute to FSAs)** |
| ▪ **Health Savings Account (HSA)** | ▪ Elect a new annual contribution amount<br>▪ Change your annual contribution amount<br>▪ Stop contributions* |

* *You can start, stop or change your contributions at any time regardless of whether you have a qualifying life event. Any changes to your contributions will take effect as soon as administratively possible, typically the first or the second pay period following the date you submit the request.*

✓ If you elect coverage for the first time, or increase your coverage to optional life insurance or optional AD&D insurance coverage after your initial eligibility period, you will be required to provide Evidence of Insurability (EOI).

If eligible, you can start, stop, or change your Health Savings Account (HSA) contributions at any time regardless of whether you have a qualifying life event. Any changes to your contributions will take effect as soon as administratively possible, typically the first or the second pay period following the date you submit the request.

## When does coverage begin?

If eligible, coverage for you and your dependents will begin as outlined in the following chart as long as you have completed your benefits enrollment **within 31 days of becoming eligible**. For life insurance, AD&D, and disability, you must also be actively at work on the day coverage is scheduled to begin. If you are absent from work on your coverage effective date, your life insurance, AD&D, and disability coverage will begin immediately upon your return to active work. If that day is a non-working day, you will be covered on that date if you were actively at work on the preceding workday.

| Benefit plan | When coverage begins |
|---|---|
| **Salaried employees** | |
| **Medical (includes prescription drug benefits)** | Date of hire |
| **Dental** | Date of hire |
| **Vision** | Date of hire |
| **Employee assistance program (EAP)** | Date of hire |
| **Flexible spending accounts (FSAs)** | Date of hire |
| **Basic life and AD&D** | Date of hire |
| **Optional life and AD&D** | Date of hire* |
| **Travel accident insurance** | Date of hire |
| **Salary continuation plan/Short-term disability (STD)** | Date of hire |
| **STD buy-up option** | Thirty days after date of hire |
| **Long-term disability (LTD)** | Date of hire |
| **LTD buy-up option** | Thirty days after date of hire |
| **APTIM 401(k) plan** | After first payroll period<br>After one year of employment — Company matching contributions begin |
| **Accident insurance** | Date of hire |
| **Hospital indemnity insurance** | Date of hire |
| **Identity Theft Protection** | Date of hire |
| **Commuter Benefit** | Date of hire |
| **Critical illness insurance** | Date of hire |

*(continued)*

| Benefit plan | When coverage begins |
|---|---|
| **Hourly/craft employees** | |
| **Medical (includes prescription drug benefits)** | First of the month following 30 days from date of hire |
| **Dental** | First of the month following 30 days from date of hire |
| **Vision** | First of the month following 30 days from date of hire |
| **Employee assistance program (EAP)** | First of the month following 30 days from date of hire |
| **Flexible spending accounts (FSAs)** | First of the month following 30 days from date of hire |
| **Basic life and AD&D** | First of the month following 30 days from date of hire |
| **Optional life and AD&D** | First of the month following 30 days from date of hire* |
| **Travel accident insurance** | First of the month following 30 days from date of hire |
| **Short-term disability (STD)** | First of the month following 30 days from date of hire |
| **Long-term disability (LTD)** | First of the month following 30 days from date of hire |
| **APTIM 401(k) plan** | After first payroll period<br>After one year of employment — Company matching contributions begin |
| **Accident insurance** | First of the month following 30 days from date of hire |
| **Hospital indemnity insurance** | First of the month following 30 days from date of hire |
| **Identity Theft Protection** | First of the month following 30 days from date of hire |
| **Commuter Benefit** | First of the month following 30 days from date of hire |
| **Critical illness insurance** | First of the month following 30 days from date of hire |

** If election is subject to Evidence of Insurability (EOI), coverage will begin on the date that the insurance company approves the EOI.*

## Benefit premium payments

Payroll deductions for your benefits will begin as soon as administratively possible upon enrollment even if you enroll after your effective date of coverage. When you terminate employment, you will pay full premiums for the last pay period in which you are enrolled regardless of whether your coverage ends before the last day of that pay period. Your premiums will not be prorated and you will not receive a refund for any days you are not covered.

## Identification cards

When you enroll in or make changes to your coverage, your medical/prescription drug and/or dental benefits administrator will send identification (ID) card(s) to your address on file with APTIM. Your ID card includes the type of plan, your coverage, phone numbers, and other information.

You should always show your ID card when you receive services so that your physician, pharmacist, or health care provider can verify your eligibility and/or submit a claim. If you do not receive an ID card or if you want additional cards, contact your elected carrier. See the *Contacts* section starting on page S-1 for contact information.

Generally, a new ID card will only be issued if you make a change to your plan option or to your covered dependents. When you show your ID card to in-network providers, the provider submits claims on your behalf, and you are only responsible for paying the applicable deductible, copay, or coinsurance.

If you enroll in vision coverage, you will not receive an ID card and one is not required to see an in-network provider. However, it is important that you remember to tell the doctor who your elected carrier is. The provider will access your information by asking a few basic questions. You may need to provide a claim form prior to receiving the service or complete a claim form for reimbursement after services are provided. You can obtain claim forms from your elected carrier.

✓ When you enroll in a Flexible Spending Account (FSA) and/or Health Savings Account (HSA), you will receive an FSA and/or HSA debit card that you can use to pay for qualified expenses. You may be required to submit documentation to substantiate debit card transactions.

## When can I change coverage?

You can make certain changes to your benefits coverage during the plan year as follows:

| If you are enrolled in the following benefit plans… | You can make certain changes to your coverage… |
|---|---|
| ▪ **Medical**<br>▪ **Dental**<br>▪ **Vision**<br>▪ **Flexible spending accounts (FSAs)**<br>▪ **Short-Term Disability (STD)** ***(hourly/craft employees only)***<br>▪ **STD buy-up option** ***(salaried employees only)***<br>▪ **Long-Term Disability (LTD)** ***(hourly/craft employees only)***<br>▪ **LTD buy-up option** ***(salaried employees only)***<br>▪ **Optional life**<br>▪ **Optional AD&D**<br>▪ **Accident insurance**<br>▪ **Hospital indemnity insurance**<br>▪ **Commuter benefit**<br>▪ **Critical illness insurance** | ▪ During annual benefits open enrollment.<br>▪ Within 31 days of a **qualifying life event**. |
| ▪ **Health Savings Account (HSA)**<br>▪ **Identity theft protection** | Anytime throughout the year by visiting the APTIM Benefits Marketplace website at digital.alight.com/aptim or by calling 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT. |

To make changes to your benefits, access the APTIM Benefits Marketplace website at digital.alight.com/aptim. You can also make changes by calling the APTIM Benefits Marketplace at 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT. The approved changes must be made within the timeframe specified in the table above.

**Generally, you have 31 days from the date of your qualifying life event to make changes to your benefits (certain exceptions apply).** Changes to your medical, dental, vision, FSAs and/or HSA will be effective on the date of your qualifying life event (for example, your baby's date of birth or the date of your marriage). Changes to your life insurance, AD&D, and/or short- and long-term disability coverage will be effective the date you enroll or on the date Evidence of Insurability (EOI) is approved (if applicable). Changes to your payroll deductions (if applicable) will be adjusted on a go-forward basis as soon as administratively possible after your qualifying life event has been processed. APTIM will not collect missed premiums back to the effective date of the change or refund any premiums.

If you do not provide notification within 31 days of a qualifying life event, you will not be permitted to change your coverage elections until the next annual benefits open enrollment period with changes effective the following January 1. If you add new dependents, you will be required to comply with the dependent eligibility audit by providing supporting documentation in order to complete your election changes (see "Dependent eligibility audit" on page A-4). If, after adding your dependents, you do not comply with the dependent eligibility audit, your dependents will be dropped from coverage with no option to elect COBRA continuation coverage. There could be consequences if you continue to cover a dependent who is no longer eligible — see "If you enroll an ineligible dependent" on page A-5.

**Coverage changes must be consistent with qualifying life event changes**

If you have a qualifying life event, you may only make coverage changes during the year that are consistent with the qualifying life event.

For example, outside of the annual benefits open enrollment period, David, who is an employee of APTIM, accessed the APTIM Benefits Marketplace website to report his recent divorce. He and his former spouse/DP were enrolled in a Bronze metallic plan and he wanted to switch to a Silver metallic plan. Is he allowed to do that?

The answer is no — the change is not consistent with the qualifying life event. David was able (and required) to drop his wife from coverage, thereby changing his coverage level and lowering the amount he had to pay for coverage, but he could not change to a different medical option.

## Qualifying life events

Qualifying life events include, but are not limited to:

- Birth, adoption or placement for adoption of a dependent child.
- Death of a spouse/DP or a dependent.
- Marriage.
- Divorce, legal separation (in states that recognize legal separation), or annulment. For more information, see "Qualifying life events that allow 60 days notice" on page A-12.
- Employment status changes that result in a change in benefits coverage for you, your spouse/DP, or your dependent(s), including:
  - A change that makes you and/or your dependent(s) eligible or ineligible for coverage under this plan or another employer's plan (other than for nonpayment of premiums or fraud).
  - Reduction in scheduled work hours to less than 20 hours per week (from full-time to part-time).
  - Increase in scheduled work hours to 20 or more hours per week (from part-time to full-time).
  - Strike or lockout.
  - Start or termination of employment.
- Qualified Medical Child Support Order (QMCSO) that requires you to provide coverage for a child.

- Significant cost or coverage change under this plan or your spouse's/DP's plan.
- You or a dependent gains or loses Medicare coverage.
- You or a dependent loses group health coverage under a state health benefits risk pool, a foreign government group health plan or an Indian tribal government plan.
- Your or your dependent's other coverage was COBRA continuation coverage and it is exhausted.
- Your dependent newly satisfies the eligibility requirements under the plan.
- Your dependent no longer satisfies the eligibility requirements under the plan. For more information, see "Qualifying life events that allow 60 days notice" on this page.
- Determination of disability by the Social Security Administration. For more information, see "Qualifying life events that allow 60 days notice" on this page.
- You or a dependent becomes eligible for, or loses eligibility for, Medicaid or a state child health plan such as the Children's Health Insurance Program (CHIP)*.

** The approved changes must be made within 60 days of the date the eligibility is lost, or within 60 days of when you or your dependent is determined to be eligible for assistance under Medicaid or a state child health plan.*

You cannot change your elections until the qualifying life event takes place. For example, filing for divorce is not a qualifying life event until the decree of divorce is actually entered.

If the qualifying life event is your or your dependent's loss of coverage under another plan, you will be required to provide a written notice from the other employer or plan indicating all family members who were covered under the other plan and the date coverage was terminated.

**Qualifying life events that allow 60 days notice**

There are certain situations in which you have 60 days to notify the APTIM Benefits Marketplace about a qualifying life event.

- If you divorce or legally separate. Your spouse/DP becomes ineligible for coverage when your divorce or legal separation (in states that recognize legal separation) is final. Your former spouse/DP will be dropped from your coverage as of that date.
- When your dependent no longer satisfies the eligibility requirements under the plan. Your dependent's coverage ends on the day he or she is no longer eligible.
- When you or a dependent receives a determination of disability by the Social Security Administration (SSA). Coverage ends on the date the determination is effective.

If you do not remove your former spouse/DP or ineligible dependent from coverage or provide notification of the SSA's determination of disability by calling the APTIM Benefits Marketplace at 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT, or via the APTIM Benefits Marketplace website at digital.alight.com/aptim within 60 days of the effective date of the change, your ineligible dependent/former spouse/DP may lose the right to continue health care coverage under COBRA (see the *Benefit Rights* section for more information on COBRA continuation coverage).

**Special enrollment rights**

You may have special enrollment rights if you decline coverage under the health care plans for yourself or your dependents because of other health insurance or group health plan coverage, and you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). For more information, see "Special enrollment rights" in the *Benefit Rights* section.

### *Newborn or adopted children*

Any dependent child born while you are covered under the plan will automatically be covered under your health care benefits on his or her date of birth. **However, you must still enroll him or her for coverage no later than 31 days after his or her birth.** If you do not add your newborn child within the first 31 days by contacting the APTIM Benefits Marketplace, health care coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable. You will need to provide documentation showing eligibility for your new dependent (see "Dependent eligibility audit" on page A-4). This also applies to a newly adopted child or a child placed with you for adoption.

## When you cannot make changes

The plan does not allow changes to any benefit elections outside of annual benefits open enrollment, with the exception of HSA, due to the following:

- A "mistake" in your enrollment.
- A reduction in your (or your spouse's/DP's) income that does not actually affect coverage under the plan.
- Unexpected expenses or anticipated expenses that did not occur.
- Other instances as permitted by applicable law.

**Take a quiz about qualifying life events!**

Which of the following are qualifying life events?

- Lindsey's 20-year-old son has no medical insurance, but Lindsey did not add him as a dependent during annual benefits open enrollment. She wants to add him now during the plan year. Can she make this change?

  *NO. She has to wait until the next annual benefits open enrollment because there is no qualifying life event.*

- Charlie's 20-year-old son, Joe, had medical insurance through his employer, but Joe's employer has just canceled that coverage. Can Charlie add Joe to his coverage?

  *YES. The difference is that Joe's loss of coverage qualifies as a special enrollment.*

- Gary just found out that his daughter, Melanie, is going to need braces. He wants to add Melanie to his dental coverage and increase his health care flexible spending account to help pay the out-of-pocket expenses. Can he make this change?

  *NO. He has to wait until the next annual benefits open enrollment because there is no qualifying life event.*

- Courtney and Dwight are thrilled that their first child has been placed with them for adoption. Can they change their medical and dental coverage?

  *YES. If they are obligated to support the child, they can change to "Employee + family" coverage and add the newly placed child onto their existing medical and dental coverage.*

## Can I continue coverage during a leave of absence?

The following is a brief summary of how your APTIM benefit plans may be impacted while on a paid or unpaid leave of absence. For more detailed information on leaves of absence and how your benefits are impacted by your particular leave, please contact APTIM Leaves, leaves@aptim.com, or reference the Leaves of Absence, AMS-500-01-PL-02000, document located in AptNet.

| Benefit plan | Can I continue benefits coverage… | | |
|---|---|---|---|
| | …during a leave while receiving a paycheck from APTIM? | …during a leave while no longer receiving a paycheck from APTIM? | ...during long-term disability? |
| **Medical (includes prescription drug benefits)** | **Yes** (Up to 6 months) | **Yes** (Up to 6 months) | **Yes** (Through COBRA) |
| **Dental** | **Yes** (Up to 6 months) | **Yes** (Up to 6 months) | **Yes** (Through COBRA) |
| **Vision** | **Yes** (Up to 6 months) | **Yes** (Up to 6 months) | **Yes** (Through COBRA) |
| **Employee assistance program (EAP) (Company-paid)** | **Yes** (Up to 6 months) | **Yes** (Up to 6 months) | **Yes** (Through COBRA) |
| **Health Care and Limited Purpose Flexible spending accounts** | **Yes** (Up to 6 months) | **Yes** (Up to 6 months) | **No** |
| **Dependent Care Flexible spending accounts** | **Yes** (Up to 6 months) | **No** | **No** |
| **Health Savings Account (HSA)** | **Yes** (Up to 6 months) | **Yes** (Up to 6 months) | **No** |
| **Basic life and AD&D (Company-paid)** | **Yes** (Up to 6 months) | **Yes** (Up to 6 months) | **No** |
| **Optional life and AD&D** | **Yes** (Up to 6 months) | **Yes** (Up to 6 months) | **No** |
| **Travel accident insurance (Company-paid)** | **Yes** (Up to 6 months) | **No** | **No** |
| **Salary continuation or short-term disability (STD), as applicable** | **Yes** (Up to 6 months) | **Yes** (Up to 6 months) | **No** |
| **Long-term disability (LTD)*** | **Yes** (Up to 6 months) | **Yes** (Up to 6 months) | **No** |

** For information on how your APTIM benefit plans are impacted while on long-term disability, see the* Long-Term Disability (LTD) Plan *section starting on page M-1.*

***Note:*** *Employees classified as being on personal hardship leave, educational leave, or breaks in service for co-op students, will have all benefits terminated effective the date of leave.*

## FMLA leave

The Family and Medical Leave Act (FMLA) of 1993 provides for continuation of benefits coverage during an unpaid leave of absence, and reinstatement of any lost coverage following a return to active leave. The following is a brief summary of the FMLA provisions that apply under the health and welfare plans.

While on an FMLA leave, you may elect to continue your benefits and that of your dependents until the earlier of:

- The expiration of the FMLA leave; or
- The date you give notice to the Company of your intent not to return to work at the end of the FMLA leave.

While on an FMLA leave, the Company will continue to make the same contributions on your behalf that it would have made had you not taken leave. You must also continue any required contributions.

In addition, if you terminate employment prior to the expiration of your leave or fail to return to work after your leave for circumstances other than those beyond your control, the Company may recover the contributions it made on your behalf while you were on FMLA leave.

### *Reinstatement of canceled insurance*

When you return to active work following an FMLA leave, any canceled insurance (health, life or disability) will be reinstated as of the date of your return, provided you complete the proper re-enrollment. You will not be required to satisfy any eligibility or benefit waiting period to the extent that it had been satisfied prior to the start of your leave.

## Paying for coverage during your leave of absence

If you are receiving a paycheck from APTIM during your leave of absence, your premium payments will continue to be deducted from your pay. If you are not receiving a paycheck from APTIM during your leave of absence, you will make premium payments on an after-tax basis.

If you are not receiving a paycheck and you are on a leave of absence for more than 30 days, you will be sent an invoice for your benefit premiums each month. You will have 30 days to pay. You can pay by:

- Automatic monthly direct deposit from your bank account set up through the APTIM Benefits Marketplace online at digital.alight.com/aptim or by calling 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT., to request an authorization form.
- Online payments with Pay Now through the APTIM Benefits Marketplace at digital.alight.com/aptim.
- Postal mail with check or money order payable to APTIM Corp. (Do not send cash or foreign currency.)

  APTIM Corp
  P.O. Box 1525
  Carol Stream, IL 60132-1525

If you do not make the required premium payments:

- If you are still on leave, your benefits may be terminated effective the last day you paid through. You will **not** be eligible for COBRA continuation coverage if your benefits are terminated due to failure to pay premiums.
- If you have returned to work, the amount due will be deducted from your pay.

If you are not receiving a paycheck and you are on a leave of absence for 30 days or less, your benefit premiums will accrue in arrears or as an "amount owed." When you return to work, the benefit premiums accrued in arrears will be deducted from your pay, in addition to the premiums for the current pay period.

## When does coverage end?

Coverage for you and your dependents ends on the earliest of these dates:

- The date of your termination.
- The date you are no longer an eligible employee.
- For your covered dependent, the date the dependent no longer meets the eligibility requirements.
- The effective date of any election by you to waive or end coverage for yourself or your dependents.
- If any required employee contributions are not made, the last day for which coverage has been paid.
- The date specified in any plan amendment resulting in loss of eligibility.
- The date your employer terminates its participation in the plan.
- The date the Company no longer offers coverage (or, in the case of insured plans, the date the group policy terminates).
- 44 days after your first day of absence due to full-time active duty in the armed forces (does not include part-time, weekend or summer-only military duty).
- If you are on a leave of absence that lasts longer than six months, your benefits will be automatically terminated after six months on a leave status.
- The date you die.

If your group health plan benefits end, you may be eligible to continue health care coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) for a certain period of time. COBRA is the same health care coverage you have as an active employee, and you pay the full cost of coverage (employee and Company contributions) plus a 2% administrative fee. Refer to "COBRA continuation coverage" in the *Benefit Rights* section for more information.

You may also be eligible to continue other coverages (for example, Life Insurance or AD&D Insurance). See the applicable sections of this SPD for details on how to continue those benefits.

### Rescission of medical coverage

Once you are enrolled and covered under the Medical Plan, your coverage may not be rescinded retroactively unless you were enrolled in the Medical Plan as a result of either:

- An act, practice or omission by you or another person, such as your spouse/DP, seeking coverage under the plan that constitutes fraud; or
- An intentional misrepresentation of a material fact.

If any of the above circumstances occurs, then both you and your affected eligible dependents will be given at least 30 days advance written notice of the rescission of coverage.

## Enrollment eligibility appeals

If you have a claim that has been denied because you are not eligible for benefits under the plan, you can submit an appeal under Section 503 of the Employee Retirement Income Security Act (ERISA) using the following process:

- Contact the APTIM Benefits Marketplace at 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT, to start the appeals process. A Claim Initiation Form will be sent to you via mail to the address on file.
- Be sure to provide a description of the nature of the claim and a statement of the reason why you think you are entitled to such coverage or benefit, including any documentation that supports your claim.
- Documents submitted for claim or appeals processing cannot be returned to you. Keep a copy of all documentation for your records.
- Mail or fax your completed Claim Initiation Form, along with copies of any documentation you feel supports your claim, to:

  Claims and Appeals Management – APTIM
  P.O. Box 1408
  Lincolnshire, IL 60069-1407

  *or*

  Fax: 833-321-0691

- A decision on your appeal will be communicated to you either in writing or by phone. Any appeal denials will include specific reasons for the decision and a reference to the plan provision on which the decision is based.

## Dependent eligibility audit appeals

If your dependent has been dropped from benefits coverage because he or she was determined to be ineligible following a dependent eligibility audit (see "Dependent eligibility audit" on page A-4), you can submit an appeal using the following process:

- Contact the APTIM Benefits Marketplace at 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT, to start the appeals process. A Claim Initiation Form will be sent to you via mail to the address on file.
- Be sure to provide the reason why you think your dependent is eligible for coverage. Be sure to include any required dependent eligibility audit documentation (such as a birth or marriage certificate) and any additional documentation that supports your claim.
- Documents submitted for claim or appeals processing cannot be returned to you. Keep a copy of all documentation for your records.
- Mail or fax your completed Claim Initiation Form, along with copies of any documentation you feel supports your claim, to:

  Claims and Appeals Management – APTIM
  P.O. Box 1408
  Lincolnshire, IL 60069-1407

  *or*

  Fax: 833-321-0691

- A decision on your appeal will be communicated to you either in writing or by phone. Any appeal denials will include specific reasons for the decision and a reference to the plan provision on which the decision is based. If the decision is made to reinstate your dependent's coverage, his or her coverage will be reinstated as of the date the coverage was originally dropped to prevent any lapse in coverage. APTIM will retroactively collect any missed or insufficient premium payments for the time period between when your dependent's coverage was originally dropped and when it is reinstated.

# Medical and Prescription Drug Plan



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

## Your medical coverage

You will have multiple options of metallic levels and carriers when selecting your medical plan. The coverage level that you choose determines how much you pay out of your paycheck (premiums). It also determines how much you pay out of your pocket when you receive care (deductibles, coinsurance, copays).

You must enroll to participate. See the *General Information* section starting on page A-1 for more information about eligibility and enrollment.

Medical coverage offers valuable benefits to help you stay healthy and pay for care if you or your covered family members become sick or injured.

The APTIM Benefits Marketplace makes it easy to find the right plan for you and your family's needs by:

- Clearly showing the premium costs associated with each plan;
- Offering a range of options at different prices;
- Helping you find the most cost-effective plan for your needs; and
- Offering one-stop shopping for additional benefits such as hospital indemnity, accident insurance and identity theft protection, so you can consider other protections alongside your medical coverage.

Your prescription drug coverage is included as part of your medical benefit.

For more information, log on to the APTIM Benefits Marketplace website at digital.alight.com/aptim or call 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT.

**Attention residents of Guam, Hawaii, Puerto Rico, U.S. Virgin Islands, and U.S. Expats**

Your medical, dental and vision benefits differ from those highlighted in the following pages. Your coverage is through the following:

- **Guam:** NetCare Life & Health Insurance
- **Hawaii:** Hawaii Medical Service Association (HMSA) or Kaiser
- **Puerto Rico:** Triple-S Insurance
- **U.S. Virgin Islands:** Cigna International
- **U.S. Expats:** Cigna International

For additional information regarding your medical, dental and vision benefits, please visit the APTIM Benefits Marketplace at digital.alight.com/aptim.

## APTIM Medical Plan options

| Plan features | Bronze<br>In-network | Bronze Plus<br>In-network | Silver<br>In-network | Gold<br>In-network | Platinum<br>In-network |
|---|---|---|---|---|---|
| **Plan deductible (including Rx)[1,2]** | $3,300/$6,600 | $2,500/$5,000 | $1,700/$3,400 | $800/$1,600 | None |
| **Coinsurance** | 25%[2] | 25%[2] | 25%[2] | 25%[2] | 0% |
| **Out-of-pocket max. (including Rx)** | $6,400/$12,800 | $4,500/$9,000 | $4,250/$8,500 | $3,600/$7,200 | $1,600/$3,200 |
| **Plan type** | PPO | PPO | PPO | PPO | PPO[6] |
| **Deductible and out-of-pocket type** | Traditional[3,5] | True Family[4,5] | True Family[4,5] | Traditional[3,5] | Traditional[3,5] |
| **Tax-savings account eligibility** | HSA or HSA and LPFSA | HSA or HSA and LPFSA | HSA or HSA and LPFSA | FSA | FSA |
| **Participant cost sharing** | | | | | |
| **Primary care/ specialist** | 25% | 25% | 25% | $25/$40 copay; no deductible | $25/$40 copay; no deductible |
| **Emergency room** | 25% | 25% | 25% | $150 copay + 25% (previously 25% only) | $200 copay |
| **Urgent care** | 25% | 25% | 25% | $40 copay | $25 copay |
| **Hospital per admission** | 25% | 25% | 25% | 25% | $350 copay |
| **Prescription drugs** | | | | | |
| **Retail** | 25%[2] | 25%[2] | 25%[2] | $10/$40/$60 copays | $8/$30/$50 copays |
| **Mail order** | 25%[2] | 25%[2] | 25%[2] | $25/$100/$150 copays | $20/$75/$125 copays |

[1] *The annual deductible doesn't include amounts taken out of your paycheck for health coverage.*

[2] *Coinsurance applies after deductible, unless otherwise noted.*

[3] *Traditional plan — Once a covered family member meets the individual deductible, your insurance will begin paying benefits for that family member. Charges for all other covered family members will continue to count toward the family deductible. Once the family deductible is met, your insurance will pay benefits for all covered family members. Once you reach your out-of-pocket max., the plan pays 100%.*

[4] *True Family plan — This means that the entire family deductible must be met before your insurance will pay benefits for any covered family members. Once the family deductible is met, your insurance will pay benefits for all covered family members. Once you reach your out-of-pocket max., the plan pays 100%.*

[5] *Go to https://aptim.makeityoursource.com to see details for out-of-network coverage.*

[6] *For some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, the Platinum coverage level is an HMO option that covers in-network care only.*

**Important notes for California residents**

If you live in California, your options will be different, depending on the insurance carrier you choose. For details about your options, see the Make it Yours website at https://aptim.makeityoursource.com and click on **Choose Benefits > Medical > California Medical Coverage Level**.

Please also note that if you are a California resident and you elect Kaiser or Health Net as your insurance carrier, new California legislation may place limits on your HSA-eligible medical plan. We highly encourage you to review your plan prior to making elections.

## Plan types

**PPO/HSA eligible** — A High Deduction Health Plan with a Preferred Provider Network. You must reach your deductible prior to any benefits being paid out, excluding wellness visits.

**PPO** — A Preferred Provider Network Plan. You pay copays for defined type of visits regardless if your deductible has been met.

## Prescription drug benefit

Your prescription drug coverage is included as part of your medical benefit. Coverage depends on the metallic level and the medical insurance carrier you choose. Make sure to check the Make It Yours site at https://aptim.content.miysource.com/medical/prescription-drugs to research carriers and explore providers and prescription drug coverage specific to APTIM plans before you are a member.

### Generic vs. brand-name drugs

Prescription drugs fall into four categories — generic, formulary, non-formulary, and specialty/biotech. The chart below outlines the differences between them:

| | |
|---|---|
| **Generic drugs** | ▪ The lowest cost alternative.<br>▪ A **generic drug** is a drug product that is comparable to a brand listed drug product in dosage form, strength, route of administration, quality and performance characteristics, and intended use. Generic drugs can provide the same benefits as their brand-name equivalent at a fraction of the cost.<br>▪ By using generic drugs, both you and the Company save money. |
| **Formulary drugs** | ▪ These cost more than generic drugs but less than non-formulary drugs.<br>▪ Formulary drugs are brand-name drugs on your elected carrier's "formulary." The formulary includes hundreds of clinically appropriate brand-name drugs that represent the prescription therapies believed to be a necessary part of a quality treatment program.<br>▪ Your elected carrier has negotiated discounted pricing on formulary drugs, which is passed on to you with a lower cost. |
| **Non-formulary drugs** | ▪ The highest cost alternative.<br>▪ Non-formulary drugs are medications that are not clinically superior to formulary alternatives and are more expensive for you and the Company. Generally, each non-formulary drug will have at least one generic or formulary alternative available at a lower cost.<br>▪ These brand-name drugs are typically covered under the prescription drug benefit, but will have a higher cost, due to there being a clinically appropriate generic or preferred substitute for that drug. |
| **Specialty/biotech drugs** | ▪ These are typically high-cost injectable, infused, oral or inhaled drugs prescribed for rare conditions or applications.<br>▪ Specialty/biotech drugs are subject to the same cost structure as in-network non-formulary drugs. |

### Use a generic when available

Generic drugs have the same active ingredients as brand-name drugs but may cost up to 80% less. As a result, the plan requires you to use generic drugs whenever possible. If a generic drug is available and *you or your physician* choose to fill your prescription with a brand-name drug, you will be required to pay the difference in cost between the brand-name drug and generic alternative. If a generic is not available, you will pay the brand-name cost only. At retail pharmacies and mail order, your prescription will automatically be filled with the generic equivalent, when available and permissible by law, unless you or your physician specifically request the use of a brand-name medication. ***Please note: This penalty amount will not apply to the deductible (if you are enrolled in a PPO/HSA Eligible plan) or the out-of-pocket maximum (under all of the Medical Plan options).***

**Example:** Member enrolled in a HDHP and has a 25% coinsurance after the deductible is met. Assuming the deductible is met, the penalty is as follows:

| | |
|---|---|
| Brand name | $ 100 |
| Generic | $ 20 |
| Member coinsurance (25% of brand) | $ 25 |
| Penalty* | $ 75 |
| **Total cost** | **$100** |

* *The penalty is $80 (difference between generic and brand). However, the penalty is reduced to $75 so as to not exceed the $100 cost of the brand name drug.*

## How deductibles work

**Bronze** and **Gold** have a traditional deductible.

Once a covered family member meets the individual deductible, your insurance will begin paying benefits for that family member.

Charges for all other covered family members will continue to count toward the family deductible. Once the family deductible is met, your insurance will pay benefits for all covered family members.

The annual deductible doesn't include premiums taken out of your paycheck for health coverage.

**Bronze Plus** and **Silver** have a "true family deductible." This means that the entire family deductible must be met before your insurance will pay benefits for any covered family members.

There is no "individual deductible" in this plan when you have family coverage. So even if one person in your family has a lot of expenses, you'll have to pay for it on your own until the full family deductible is met.

The annual deductible doesn't include premiums taken out of your paycheck for health coverage.

### Platinum coverage level

The **Platinum** coverage level does not have an in-network deductible. Keep in mind that as a trade-off for no deductible, the Platinum coverage level is usually the most expensive coverage level per paycheck.

## How out-of-pocket maximums work

**Bronze**, **Gold**, and **Platinum** have a traditional out-of-pocket-maximum.

Once a covered family member meets the individual out-of-pocket maximum, your insurance will pay the full cost of covered charges for that family member.

Charges for all covered family members will continue to count toward the family out-of-pocket maximum. Once the family out-of pocket maximum is met, your insurance will pay the full cost of covered charges for all covered family members.

It doesn't include premiums taken out of your paycheck for health coverage. Also, if you choose coverage under Kaiser Permanente, copays for certain medical benefits may not apply towards the annual out-of-pocket maximum under the Gold and Platinum options.

**Bronze Plus** and **Silver** have a "true family out-of-pocket maximum." This means that the entire family out-of-pocket maximum must be met before your insurance will pay the full cost of covered charges for any covered family member.

There is no "individual out-of-pocket maximum" in this coverage level when you have family coverage.

The annual out-of-pocket maximum doesn't include premiums taken out of your paycheck for health coverage.

## Do you use out-of-network providers?

Out-of-network charges will not count toward your in-network deductible or out-of-pocket maximum. The same goes for in-network charges — they will not count toward your out-of-network deductible or out-of-pocket maximum.

And some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA do not cover out-of-network benefits at all.

## How copays work

Under the Gold and Platinum Plans, some covered services require you to pay a fixed charge called a "copayment" or "copay." The coverage level that you choose determines the amount of your copay. **Copays do not count toward your annual deductible, but they do count toward the annual out-of-pocket maximum.**

## How coinsurance works

After you meet the applicable deductible, the Medical Plan pays a percentage of eligible charges and you pay the rest — this is called "coinsurance." Coinsurance payments that you pay apply toward your annual out-of-pocket maximum. The employee portion of Coinsurance, where applicable, is 25% for Bronze, Bronze Plus, Silver, and Gold. The employee portion of Coinsurance for Platinum is 0%.

## Cost of coverage

How much you pay for medical coverage depends on:

- The amount of your contribution from APTIM;
- The metallic level you choose;
- The insurance carrier you choose; and
- How many dependents you enroll.
  - Employee only.
  - Employee + spouse/domestic partner (DP).
  - Employee + child(ren).
  - Employee + family.

All eligible employees will receive a company contribution to use toward the cost of coverage. You will see the contribution amount from APTIM and your price options for coverage when you enroll.

The **Bronze**, **Bronze Plus**, and **Silver** coverage levels cost less per paycheck, but you will pay more out of pocket when you need care. The **Gold** and **Platinum** coverage levels cost more per paycheck but your deductible is lower (Platinum coverage does not have an in-network deductible), so you'll probably pay less out of pocket for services throughout the year.

You can compare the costs of different insurance carriers for each coverage level on the APTIM Benefits Marketplace website at digital.alight.com/aptim during enrollment.

## Spousal/domestic partner (DP) surcharge

If your legally married spouse/DP is eligible for other employer-sponsored medical coverage but chooses coverage under the APTIM Benefits Marketplace, you will be required to pay a monthly surcharge of $125 in addition to your medical payroll deduction. You will be asked during the process whether your spouse/DP is eligible. Employees will be required to attest the information provided is accurate during the enrollment process.

If you and your spouse/DP are both benefits-eligible full-time APTIM employees, you may each enroll in medical coverage as an employee, or one of you can cover the other employee as a dependent. If you both enroll as employees, only one of you may cover your eligible children. The Spousal/DP Surcharge will not apply.

If your spouse/DP does not have access to employer-sponsored coverage or gains access to Medicare, the Spousal/DP Surcharge will not apply. Employees will be required to attest the information provided is accurate during the enrollment process. If your spouse/DP previously had access to coverage and then lost that coverage, the spousal/DP surcharge can be removed during the year.

## Coordination with Medicare

Benefits under the Medical Plan are primary to Medicare to the extent required by the Social Security Act of 1965. The Medical Plan will assume the amount payable under:

- Medicare Part A if you are eligible for Part A, even if you have not applied for or are not receiving a benefit.
- Medicare Part B if you are entitled to Part B, even if you are not enrolled.

The Medical Plan will pay benefits as if you had applied for Medicare Part A or were enrolled in Medicare Part B, as applicable.

However, in the event you become eligible for or entitled to Medicare as a result of end-stage renal disease (ESRD), when required, the Medical Plan will be primary only during the first 30 months of your entitlement. Thereafter and when permitted, the Medical Plan becomes secondary and determines benefits after Medicare, even if the individual has not accepted enrollment. Please contact your provider for additional information. Additional information can also be found on the Medicare website at www.medicare.gov.

## TRICARE

TRICARE is the U.S. Department of Defense health benefit program for the military community.

The Company offers a TRICARE Supplement Plan to eligible active employees who have served in the military. TRICARE Supplement helps pay your portion of medical costs after your primary TRICARE plan has paid.

Supplemental TRICARE benefits are provided by Selman & Co. To be eligible, you must be enrolled in the Defense Enrollment Eligibility Reporting System (DEERS) and you must **not** be eligible for Medicare. Eligible individuals include:

- Military retirees receiving retirement, retainer, or equivalent pay and spouses/surviving spouses or military retirees;
- Retired reservists between the ages of 60 and 65 and their spouses/surviving spouses;
- Retired reservists younger than 60 and enrolled in TRICARE Retired Reserve ("Gray Area" retirees) and their spouses/surviving spouses; and
- Qualified National Guard and Reserve members.

If you are eligible and wish to enroll in the TRICARE Supplement Plan, you can contact Selman at 1-800-638-2610, option 1, or access their website at www.selmantricareresource.com/aptim.

## Summary of benefits and coverage

To review a summary of benefits and coverage for your specific elected plan, which includes prescription coverage, please go to digital.alight.com/aptim and click on **Medical > View all Coverage Details > Plan Facts > Coverage Details**. This will provide you detailed information on covered services, non-covered services, limitations and restrictions, etc.

# Health Savings Account (HSA)



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

## Your Health Savings Account (HSA)

When you enroll in a Bronze, Bronze Plus, or Silver Health Savings Account (HSA) eligible plan, you will have the option to contribute to an HSA on a tax-free basis, if eligible.

You use the funds in your HSA to pay eligible health care expenses, including medical, prescription drug, dental, orthodontia, and vision expenses. Each year you enroll in an HSA:

- You have the option to contribute pre-tax money into your account, up to IRS limits (see page C-3 for these limits).
- You can use your HSA to pay for qualified medical, dental, vision, and prescription drug expenses, including your annual deductible. Or, you can pay for these expenses yourself, save and invest your HSA funds and use the money for future health care expenses.
- The money in your HSA is yours to keep. Any amount that you do not use during the plan year may be rolled over from year to year, and the funds can earn interest tax-free. When your HSA balance reaches a certain level, you have the option to invest a portion of it in a wide array of mutual fund options.
- The HSA is portable, so if you leave APTIM, you can take it with you.

✓ If you elect coverage under another non-qualified medical option or waive medical coverage — or if your employment or eligibility under the Medical Plan ends during the year — you are not eligible to make additional contributions to your HSA. However, the money already in your HSA is yours to keep.

## Eligibility

Since an HSA is a tax-advantaged savings account, you have to meet certain requirements to be eligible to participate in an HSA and make pre-tax contributions into an HSA:

- You must be enrolled in an HSA-eligible plan, which is a qualified high deductible health plan.
- You cannot be enrolled in another medical plan (e.g., your spouse's/domestic partner's (DP) plan), unless it is also a qualified high deductible health plan.
- You cannot be enrolled in Medicare.
- You cannot be eligible to be claimed as a dependent on another individual's tax return.

**Note: If you are enrolled in any part of Medicare, you are not eligible to make or receive contributions into an HSA.** If you have an existing HSA and then enroll in Medicare, you may continue to draw on your HSA funds, but you may no longer contribute to your account. If you defer enrollment in Medicare past your 65th birthday, you are eligible to continue participation in an HSA until you enroll in Medicare. For example, if you are an active employee enrolled in an HSA-eligible plan on your 65th birthday and defer enrollment in Medicare, you can continue to make pre-tax contributions into your HSA. If you then retire when you are age 67 and enroll in Medicare at that time, your contributions to your HSA will be discontinued but you can still use your HSA account balance to pay qualified health care expenses.

Please refer to IRS Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans, available at http://www.irs.gov/pub/irs-pdf/p969.pdf, for more information about eligibility for HSAs.

## How the HSA works

When you enroll in an HSA-eligible plan, an HSA will automatically be opened on your behalf with Bank of America. HSA accounts can only be opened with a physical address. If you currently use a P.O. Box as your primary address, you will need to give Bank of America a physical address before the funds in your account can be utilized. Bank of America will reach out to you via mail if additional information is needed to open your account.

Once your account is open, you may contribute to your HSA on a tax-free basis each year you are enrolled in an HSA-eligible plan.

- If you stop participating in an HSA-eligible plan, you can use the funds remaining in your HSA for eligible medical expenses, but you can't make any new contributions to the HSA.
- You have the option to make pre-tax contributions to your account, up to IRS limits (see "HSA contribution limits" below for these limits). Depending on where you live, contributions to the HSA may be subject to state and/or local taxes. When you open an HSA, contributions are deducted from your paycheck in equal installments throughout the year. You can change your contribution amount at any time during the year by visiting the APTIM Benefits Marketplace website at digital.alight.com/aptim or by calling 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT. Any changes to your contributions will take effect as soon as administratively possible, typically the first or the second pay period following the date you submit the request.

✓ According to federal guidelines, if you are enrolled in an HSA-eligible plan, you cannot open a Health Care Flexible Spending Account (FSA); however you can participate in a Limited Purpose FSA. Contributing to a Limited Purpose FSA allows you to reserve your HSA funds for true medical expenses or for building up your account balance so you can invest your money in mutual funds through Bank of America. See the *Flexible Spending Accounts (FSA)* section starting on page F-1 for more information on the Limited Purpose FSA.

## HSA contribution limits

The HSA contribution limits maximums are per household. If your spouse/DP also contributes to an HSA, the maximum amount you can contribute is reduced by your spouse's/DP's contribution.

| Coverage level | 2025 contribution limits |
|---|---|
| **Employee only** | $4,300* |
| **Employee plus any dependents** (Employee + spouse/DP, Employee + child(ren), Employee + family) | $8,550* |

** If you are age 55 or older and not enrolled in Medicare, you can make an additional $1,000 "catch-up" contribution.*

- You are the account holder, and you are responsible for reporting HSA contributions and distributions to the IRS.
- If you are age 55 or older, you can make additional "catch-up" contributions of $1,000 a year, including the year in which you turn age 55, until you enroll in Medicare.
- If you have contributed more than the annual limit to your HSA, you may withdraw the excess amount, including earnings, prior to the due date (which may include extensions on your tax return). However, you must pay income tax on your excess contributions, including any earned interest on those contributions.
- If you do not timely withdraw any excess HSA contributions (including earnings), you will have to pay a 6% excise tax on the excess contributions and earned interest. You will have to pay the 6% excise tax each year the excess contributions and earnings remain in the HSA. Once you have withdrawn the excess contributions and earnings, you should decrease your contribution amount to the annual limit to avoid the excise tax.

Please refer to IRS Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans, available at www.irs.gov/publications/p969, for more information about annual contribution limits.

**Note:** You are responsible for monitoring and adjusting your contributions throughout the year to ensure compliance with federal laws and limitations that apply to HSAs.

### *Contribution limits for mid-year enrollments*

If you enroll in benefits during the year, you may be eligible to contribute up to the full annual HSA contribution limit during the year in which you enroll. **Be sure to review these limits carefully if you are enrolling in an HSA-eligible plan during the plan year.**

- You can contribute a prorated amount, up to the annual IRS limits, based on the actual number of months you are eligible. For example, if you are under age 55 and enroll in "Employee only" coverage under an HSA-eligible plan effective August 1, you can contribute up to $860/month for the five months remaining in the year, for a total contribution of up to $4,300.
- If you become eligible to make contributions to an HSA on December 1, you may contribute the full annual contribution amount ($4,300 for "Employee only" coverage or $8,550 for all other coverage levels — plus an additional $1,000 if you are age 55 or older) as long as you remain eligible for the HSA for the 12 months following the end of the year. If you become ineligible during those 12 months, your contributions will be included as taxable income and subject to applicable taxes.
- If you enroll in an HSA-eligible plan with an effective date on or after December 2, you are not eligible to contribute to the HSA until January 1.

## Participating in the HSA

Here is an overview of how to use the HSA.

| Step | Details |
|---|---|
| **1. Enroll in an HSA-eligible plan.** | When you enroll, an HSA is automatically opened in your name with Bank of America. If you already have an HSA, contributions will automatically go into your existing APTIM account. If you have a Bank of America account through a previous employer, you will have to roll those funds over into the APTIM account. **Please remember that HSAs can only be opened with a physical address. If you use a P.O. box as your primary address, you will need to give Bank of America a physical address before the funds in your account can be utilized.** |
| **2. You contribute.** | If you elect to contribute, your contributions are deducted from your paychecks on a pre-tax basis in equal installments throughout the year. You can change your contribution amount at any time during the year by visiting the APTIM Benefits Marketplace website at digital.alight.com/aptim or by calling 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT. Any changes to your contributions will take effect as soon as administratively possible, typically the first or the second pay period following the date you submit the request. See "HSA contribution limits" on page C-3. |
| **3. You incur expenses.** | See page C-6 for qualified expenses. If you use the money in your HSA for ineligible expenses, you will be taxed on the money used for those expenses and could possibly incur a penalty from the IRS. |
| **4. You pay expenses directly from your HSA or receive reimbursement from your account.** | ▪ You will receive an HSA debit card from Bank of America that you can use to access your HSA funds when paying for qualified expenses.<br>▪ You can also pay for qualified expenses yourself and request reimbursement from your account by accessing the Bank of America website. See "How to file a claim" on page C-7 for more information.<br>▪ Unlike the Health Care and Limited Purpose flexible spending accounts, you can make payments or withdrawals from your HSA ***only up to your current account balance***. Your pre-tax contributions must accumulate in the account before you can use them. |
| **5. Invest your balance.** | Funds in your account will earn tax-free interest. In addition, you have the option to invest a portion of your HSA in a wide array of mutual fund options. You can use your investment money to pay for current or future expenses. |
| **6. Keep your account balance.** | ▪ There is no "use it or lose it" rule — your account balance rolls over from year to year if you do not use it all.<br>▪ You can use your HSA for current expenses or save and invest the money for future health care expenses.<br>▪ Your account will remain open while you are an APTIM employee, even if you change health care plans.<br>▪ The HSA is portable, so if you leave APTIM, you can take it with you. |

You will receive a new HSA debit card and welcome letter in the mail from Bank of America. The debit card will be sent separate from the welcome letter. You will need to activate your new Bank of America HSA debit card before use.

**Contact Bank of America**

If you prefer to pay the provider yourself for qualified expenses and request reimbursement from your account, you can do so online.

- Log in to the Bank of America website at https://myhealth.bankofamerica.com.
- You may contact Bank of America by phone at 1-866-791-0250.

**Check your address**

When you enroll in the Health Savings Plan, an HSA will automatically be opened on your behalf with Bank of America. HSA accounts can only be opened with a physical address. If you currently use a P.O. Box as your primary address, you will need to give Bank of America a physical address before the funds in your account can be utilized. Bank of America will reach out to you via mail if additional information is needed to open your account.

**Matt prepares for retirement**

Matt has "Employee + spouse/DP" coverage under an HSA-eligible plan for himself and his wife, Sharon. His HSA has grown to $17,500. He is 64 years old and is thinking of retiring next year. But Matt and Sharon are both still quite healthy, and they are worried about what will happen to the money in the HSA if they do not use it all by the end of the year.

Rest assured — Matt does not need to be concerned. Unlike flexible spending accounts, which have a "use it or lose it" rule, HSAs can roll over from year to year. What is even better is that Matt's HSA balance is his to keep even when he leaves APTIM. He can roll over the money in his HSA to another qualified account and take it with him when he retires to help pay retiree medical expenses.

## Eligible expenses

Your HSA can only be used to pay for IRS-qualified health care expenses for you and your covered dependents. Generally, you can use your HSA to pay for any expenses that would be considered tax-deductible medical expenses for federal income tax purposes. Examples include, but are not limited to:

- Medical expenses not paid by the Medical Plan, including your annual deductible.
- Dental expenses.
- Vision expenses.
- Prescription drug expenses.
- Over-the-counter medications with a doctor's prescription.

In addition, certain premium payments are eligible for reimbursement from your HSA. These include:

- Qualified long-term care insurance premiums.
- Medicare premiums, if you are age 65 or over (excluding Medigap).
- Premiums for health care continuation insurance, such as COBRA.

✓ For a complete list of eligible and ineligible HSA expenses, please see IRS publication 502, Medical and Dental Expenses. This publication is available online at http://www.irs.gov/pub/irs-pdf/p502.pdf.

## Ineligible expenses

Be sure to check if the health care expense is eligible before you use HSA funds. Any funds you withdraw from your HSA that are **not** used for qualified health care expenses will be subject to Federal income tax at your current tax rate plus an additional 20% tax. If you use money from your HSA for ineligible expenses, you must report those withdrawals accordingly. You should maintain records of all HSA expenses — neither APTIM nor HSA Bank are responsible for documenting the expenses associated with distributions from your HSA.

If you make a withdrawal for a health care expense that you reasonably thought was eligible, but it turned out to be ineligible, you may be able to return the money to your HSA on or before April 15th of the year following the year in which you mistakenly withdrew the funds. Contact Bank of America for more information.

**IMPORTANT**

Be sure to save all receipts and keep track of the expenses paid from your HSA. The IRS could request these records during a tax audit.

If you use your HSA to pay eligible health care expenses, then you are not required to report those expenses as taxable income on your tax return. However, if you use your HSA for **ineligible** expenses, you are responsible for reporting the distribution(s) as taxable income and paying income taxes on that amount plus an additional 20% tax. The 20% penalty does not apply to distributions made if you become disabled, after age 65 or after your death. Consult your tax advisor to determine how your particular situation may affect your HSA or your tax return.

APTIM and Bank of America are not responsible or liable for the misuse of HSA funds or for the distribution of HSA funds for non-qualified expenses.

## How to file a claim

You can make payments or withdrawals from your HSA only up to your current account balance. There is no time limit for reimbursements — as long as your HSA was open when you incurred the expense, you can be reimbursed from your account at any time.

### HSA debit card

You will receive a debit card from Bank of America that you can use to access your HSA funds when paying for qualified expenses. When you use the debit card, you will not have to pay out-of-pocket for the expenses or reimburse yourself later. Just use the card to pay for qualified expenses, and the amount will be paid directly to the provider, as long as there are sufficient funds in your HSA.

- If there are sufficient funds to cover only part of the expense and the provider allows partial payments, you can use your debit card to pay for the expense up to your account balance and pay the rest out-of-pocket. If the provider does not allow partial payments or your HSA funds have been depleted, the transaction will be denied and you will have to pay the entire expense out-of-pocket.
- It is always a good idea to save your receipts, even if you use the debit card to pay for eligible expenses.
- The debit card may only be used at locations that are designated as health care merchants based on their Merchant Category Code.
- You can request additional or replacement debit cards online at https://myhealth.bankofamerica.com or by calling 1-866-791-0250.
- Your debit card remains active even after your HSA funds for the plan year have been depleted. HSA funds for subsequent plan years are added to the original debit card until it expires after three years. If you are still eligible for the HSA, a new debit card is automatically reissued when your card expires.

### Other payment and reimbursement options

If you would rather pay the provider yourself for qualified expenses, you can request reimbursement from your HSA by logging in to your account at https://myhealth.bankofamerica.com.

You can receive reimbursement from your HSA by check or through direct deposit. You do not need to submit receipts for approval, but it is important to keep your receipts for record-keeping purposes or in case you need to show you are reimbursing yourself for a qualified expense. Call Bank of America at 1-866-791-0250 if you have any questions about payments or reimbursements.

## Other important information

HSAs are accounts established for the purpose of offsetting participant health care expenses. HSAs are not held in a trust and not funded by APTIM.

### If you leave APTIM

If you leave APTIM, Bank of America will not close out your HSA. Your existing account and debit card will remain open and active, but will no longer be administered through APTIM. You will still be able to access your account information through Bank of America to make contributions, receive reimbursements or make payments, request debit cards, or for any other HSA transactions. A monthly fee to administer the HSA will be debited directly from your account.

If you choose to transfer your HSA funds to another eligible account, you must do so within 60 days from the date that HSA funds are received by you to avoid paying taxes on the balance. If you elect COBRA, you can use the HSA to pay your COBRA premiums and out-of-pocket costs under the Medical Plan as long as you maintain COBRA coverage.

If you have questions, please call Bank of America at 1-866-791-0250.

### Rollovers from another HSA

If you have a balance in another HSA that you wish to transfer into your APTIM Bank of America account, you should complete an HSA Bank rollover form and submit it to your prior employer or prior custodian per the instructions on the form. Your prior custodian will process the request to transfer funds and should provide a check payable to "Bank of America." The check should be sent to Bank of America to deposit into your HSA account.

The prior custodian must include a copy of the rollover form to ensure prompt posting of the funds to the correct account. If Bank of America cannot identify the recipient of the funds, the check may be returned to the prior custodian and the rollover may be delayed. If you contact Bank of America to verify the status of the rollover, you will need a check number from the previous bank, the date on the check and the amount.

# Dental Benefits



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

## Your dental coverage

You will have multiple options of metallic levels and carriers when selecting your dental plan. The coverage level that you choose determines how much you pay out of your paycheck (premiums). It also determines how much you pay out of your pocket when you receive care (deductibles, coinsurance, copays).

You must enroll to participate. For more information on eligibility and enrollment, see the *General Information* section starting on page A-1.

Dental coverage offers valuable benefits to help you stay healthy and pay for dental care for you and your covered family members.

The APTIM Benefits Marketplace makes it easy to find the right plan for you and your family's needs by:

- Clearly showing the costs associated with each plan;
- Offering a range of options at different prices; and
- Helping you find the most cost-effective plan for your needs.

For more information, log on to the APTIM Benefits Marketplace website at digital.alight.com/aptim or call 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT.

## Dental coverage level options

| Plan features | Bronze | Silver | Gold |
|---|---|---|---|
| **Annual deductible and plan limits** | | | |
| **Annual deductible (individual/family)** | $100/$300 | $100/$300 | $50/$150 |
| **Annual maximum (excludes orthodontia)** | $1,000 per person | $1,500 per person | $2,500 per person |
| **Orthodontia lifetime maximum*** | Not covered | $1,500 per child | $2,000 per person |
| **In-network benefits** | | | |
| **Preventive care** | 100% covered, no deductible | 100% covered, no deductible | 100% covered, no deductible |
| **Minor restorative care (e.g., root canal treatment, gum disease treatment, and oral surgery)** | You pay 20% after deductible | You pay 20% after deductible | You pay 20% after deductible |
| **Major restorative care (e.g., implants, dentures)** | Not covered | You pay 40% after deductible | You pay 20% after deductible |
| **Orthodontia** | Not covered | You pay 50%, no deductible; children up to age 19 only | You pay 50%, no deductible; for children and adults |

** If you switch insurance carriers, any orthodontic expenses you've already incurred under your current carrier will count toward your new carrier's orthodontia lifetime maximum.*

***Note:*** *For additional comparison, you may find Summaries of Benefits and Coverage on the APTIM Benefits Marketplace website or via APTNET on the Benefits homepage, https://aptimcorp.sharepoint.com/hr/benefits/Pages/Home.aspx.*

## Deductibles and maximums

### Annual deductible

Your deductible is the amount you pay each calendar year for covered services before the plan begins to share in the cost of covered services with you. The metallic level that you choose determines your annual deductible.

### Benefit maximums

The **annual maximum benefit** is the maximum amount the plan will pay each calendar year for each covered person's covered dental expenses. It applies to non-orthodontia benefits.

The **lifetime maximum benefit for orthodontia** is the maximum amount the plan will pay for each covered person's orthodontia expenses. This lifetime maximum is separate from the annual maximum benefit described above.

### Coinsurance

After you meet the annual deductible, if applicable, the plan pays a percentage of eligible charges and you pay the rest — this is called "coinsurance." The metallic level that you choose determines how much you pay in coinsurance for covered services. The type of service also determines coinsurance.

## What does coverage cost?

How much you pay for dental coverage depends on:

- The amount of your contribution from APTIM;
- The metallic level you choose;
- The insurance carrier you choose; and
- How many dependents you enroll.
  - Employee only.
  - Employee + spouse/domestic partner (DP).
  - Employee + child(ren).
  - Employee + family.

All eligible employees will receive a company contribution to use toward the cost of coverage. You will see the contribution amount from APTIM and your price options for coverage when you enroll.

### If you use out-of-network dentists

The plan may pay benefits if you elect to see an out-of-network provider. See "Summary of benefits and coverage" on this page on how to check your elected carrier's plan details.

## Summary of benefits and coverage

To review a summary of benefits and coverage for your specific elected plan, please go to digital.alight.com/aptim and click on **Dental > View all Coverage Details > Plan Facts > Coverage Details**. This will provide you detailed information on covered services, non-covered services, limitations and restrictions, etc.

# Vision Benefits



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

## Your vision coverage

You will have multiple options of metallic levels and carriers when selecting your vision plan. The coverage level that you choose determines how much you pay out of your paycheck (premiums). It also determines how much you pay out of your pocket when you receive care (deductibles, coinsurance, copays).

You must enroll to participate. See the *General Information* section starting on page A-1 for more information about eligibility and enrollment.

Vision coverage offers valuable benefits to help you and your covered family members get eye care.

The APTIM Benefits Marketplace makes it easy to find the right plan for you and your family's needs by:

- Clearly showing the costs associated with each plan;
- Offering a range of options at different prices; and
- Helping you find the most cost-effective plan for your needs.

For more information, log on to the APTIM Benefits Marketplace website at digital.alight.com/aptim or call 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT.

## Vision coverage level options

| Plan features | Bronze | Silver | Gold |
|---|---|---|---|
| **In-network benefits** | | | |
| **Routine vision exam (once per plan year)** | Covered 100% | You pay $20 | You pay $10 |
| **Frames (once per plan year)** | Discount may apply | $130 allowance[1] | $200 allowance[1] |
| **Lenses (once per plan year; premium lenses may cost more)** | | | |
| **Single vision, bifocal, trifocal, standard progressive[2], or lenticular** | Discount may apply | You pay $20 | You pay $10 |
| **Lens enhancements** | | | |
| **UV treatment** | Discount may apply | You pay $15 | You pay $15 |
| **Tint (solid and gradient)** | Discount may apply | You pay $15 | You pay $15 |
| **Standard plastic scratch-resistant coating** | Discount may apply | You pay $15 | You pay $15 |
| **Standard anti-reflective coating** | Discount may apply | You pay $45 | You pay $45 |
| **Standard polycarbonate (adults)** | Discount may apply | You pay $40 | You pay $15 |
| **Standard polycarbonate (children)** | Discount may apply | You pay nothing | You pay nothing |
| **Other add-ons** | Discount may apply | Discount only | Discount only |
| **Contact lenses** | | | |
| **Medically necessary** | Not covered | You pay $20 | You pay $10 |
| **Elective** | Not covered | $130 allowance[1] | $200 allowance[1] |
| **Fit and evaluation** | Discount may apply | You pay $20 | You pay $10 |
| **Laser surgery** | | | |
| **Elective** | 15% off regular price or 5% off promotional price | 15% off regular price or 5% off promotional price | 15% off regular price or 5% off promotional price |

[1] *Allowance can be used for frames or elective contact lenses, but not both.*

[2] *Vision benefits are for standard progressives. Enhanced progressives may cost more and will vary by insurance carrier.*

***Note:*** *Safety glasses are not included as part of your vision plan. For more information and additional comparisons, you may find Summaries of Benefits and Coverage on the APTIM Benefits Marketplace website or via APTNET on the Benefits homepage, https://aptimcorp.sharepoint.com/hr/benefits/Pages/Home.aspx.*

## Copay and allowance

It is important to know the following terms to understand how the plan determines your costs for covered services:

- **Copay** — A fixed charge you pay when you obtain services or products through your elected carrier's network. For example, you are charged a $10 copay for an annual eye exam when you go to an in-network provider. The plan generally pays the rest of the allowable cost. Please note that copay amounts may vary depending on the metallic level and carrier you select.
- **Allowance** — The maximum dollar amount the plan pays toward certain services or products (for example, frames or elective contacts) in a calendar year, as shown in the "Vision coverage level options" chart on this page. You are responsible for charges over the allowance.

## Out-of-network providers

The plan may pay benefits if you elect to see an out-of-network provider. See "Summary of benefits and coverage" on this page on how to check your elected carrier's plan details.

## What does coverage cost?

You pay the entire cost of vision coverage. How much you pay for vision coverage depends on:

- The metallic level you choose;
- The insurance carrier you choose; and
- How many dependents you enroll.
  - Employee only.
  - Employee + spouse/domestic partner (DP).
  - Employee + child(ren).
  - Employee + family.

## Summary of benefits and coverage

To review a summary of benefits and coverage for your specific elected plan, please go to digital.alight.com/aptim and click on **Vision > View all Coverage Details > Plan Facts > Coverage Details**. This will provide you detailed information on covered services, non-covered services, limitations and restrictions, etc.

# Flexible Spending Accounts (FSA)



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

## Your Flexible Spending Account (FSA) options

Flexible Spending Account (FSA) programs let you set aside pre-tax dollars from your paycheck to pay for eligible healthcare and/or dependent care expenses. Each year, you can choose to participate in the spending accounts:

- The Health Care FSA reimburses you for eligible *health care/medical* costs incurred by you or your family members that are not paid by any other health insurance or coverage.
- The Limited Purpose FSA reimburses you for qualifying out-of-pocket *dental and vision* expenses. Once your deductible is met, it can be used on eligible health care/medical costs.
- The Dependent Care FSA reimburses you for certain *day care* expenses for children and dependent adults.

The Health Care FSA, Limited Purpose FSA, and Dependent Care FSA are separate accounts and are designed for different types of expenses. Deposits to your Dependent Care FSA **cannot** be used to reimburse yourself for health care expenses incurred by you or your dependents. Likewise, deposits to your Health Care FSA or Limited Purpose FSA **cannot** be used for dependent care expenses.

Participation is entirely voluntary. You may have a Health Care or Limited Purpose FSA **and** a Dependent Care FSA. You may also elect just one FSA or no FSA at all.

**Estimating your expenses**

A "use it or lose it" rule applies to the FSAs, which means account balances do not roll over from year to year and you cannot be reimbursed any unused funds. You should try to predict as closely as possible how much you will actually spend during the year. For more information on how these accounts can work for you, visit the APTIM Benefits Marketplace at digital.alight.com/aptim or call 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT.

## Eligibility

### For yourself

You must enroll to participate. See the *General Information* section starting on page A-1 for more information about eligibility and enrollment.

You are eligible to participate in a Dependent Care FSA, even if you are not enrolled in the APTIM medical plan. However, you must be enrolled in a High-Deductible Health Care Plan to participate in a Limited Purpose FSA.

### For your dependents

The FSAs allow you to use pre-tax dollars to pay for certain health care and dependent care expenses for yourself and your eligible dependents. Due to IRS regulations, dependents are defined differently for each type of spending account.

See "Dependent eligibility for the Health Care and Limited Purpose FSAs" on page F-6 and "Dependent eligibility for the Dependent Care FSA" on page F-10.

## How the accounts work

### Tax advantages

In general, Flexible Spending Accounts save you money by reducing your taxable income. Specifically, your FSA contributions are not subject to Social Security, Medicare, federal and most state and local taxes. The result is an increase in your spendable income.

Plan carefully as you decide how much to set aside for the year, because you forfeit any money for which you do not have eligible expenses by the end of the year. Eligible expenses must be incurred by December 31 of the plan year in which you are participating, and claims must be filed no later than March 31 of the following year.

### *Savings example*

How much money can you really save by using a Flexible Spending Account? That depends on many factors including the amount of your health and dependent care expenses, your annual income, and your tax rates. The following example illustrates how an FSA could potentially save money for an employee.

**Robert's tax savings**

Robert, an APTIM employee, has one child in day care part-time, for the days he and his wife are at work. Robert and his wife decided to estimate how using the Dependent Care FSA and the Health Care FSA might affect their income.

| | With FSA | Without FSA |
|---|---|---|
| Annual family income | $70,000 | $70,000 |
| Health Care FSA contribution | 2,000 | 0 |
| Dependent Care FSA contribution | 2,500 | 0 |
| Taxable income | 65,500 | 70,000 |
| Estimated federal income tax (25%) | 16,375 | 17,500 |
| Social Security and Medicare (7.65%) | 5,010 | 5,355 |
| After-tax health care and dependent care expenses | 0 | 4,500 |
| Net pay | $44,115 | $42,645 |
| **FSA tax savings** | **$ 1,470** | |

In this example, Robert would have an extra $122 each month in take-home pay by using the FSAs to pay for his health care and dependent care expenses.

## 2025 FSA contribution limits

| | Health Care FSA | Limited Purpose FSA | Dependent Care FSA |
|---|---|---|---|
| **Minimum annual contribution** | $100 | $100 | $100 |
| **Maximum annual contribution** | $3,300 | $3,300 | ▪ $5,000 for single taxpayers and for married taxpayers filing a joint return[1,2]; or<br>▪ $2,500 for married taxpayers filing separate returns[1,2]. |

[1] *Contributions cannot exceed the lesser of your or your spouse's/DP's earned income. Or, if your spouse/DP is a full-time student or is disabled, you may contribute up to $3,000 for one dependent or $5,000 for two or more dependents.*

[2] *The amount you elect for 2025 could be decreased midyear if the Company thinks the plan is going to fail IRS discrimination testing to avoid returning any monies and any penalties for you as a participating employee.*

Once you make your FSA elections, you may not change your contribution amounts during the year unless you have a qualifying life event. See "Changing your elections" on page F-15.

## Participating in the FSAs

Although the Health Care FSA, Limited Purpose FSA, and Dependent Care FSA cover different expenses, the process of using them is generally the same. This is how it works:

| Step | Details |
|---|---|
| **1. You enroll.** | You decide if you want to participate in the FSAs when you are first employed or during the annual benefits open enrollment period, and how much to contribute for the year.<br>▪ You should try to predict as closely as possible how much you will actually spend during the year because federal government regulations prevent reimbursement of any unused funds.<br>▪ It is beneficial to include all anticipated costs to take advantage of as much tax savings as possible.<br>▪ Please note that your enrollment in the FSAs does not roll over from year to year, and you must re-enroll each year you wish to participate. |
| **2. You contribute.** | Your contributions are automatically deducted from your paychecks on a pre-tax basis in equal installments throughout the year and credited into the Flexible Spending Account(s) you elect.<br>**Note:** The amount you elect to contribute to an FSA is divided by the number of pay periods in a calendar year (26 pay periods for eligible biweekly employees and 52 pay periods for eligible weekly employees), or by the number of pay periods left in the year. If your goal amount is not equally divisible by the number of pay periods, your actual contributions may be slightly different than your goal amount. |
| **3. You incur expenses.** | See page F-7 for eligible Health Care FSA expenses, page F-8 for eligible Limited Purpose FSA expenses and page F-11 for eligible Dependent Care FSA expenses. |
| **4. You receive reimbursements.** | ▪ Upon enrollment in an FSA, you will receive a debit card to pay for qualified expenses at the point of sale. This means you will not have to pay for expenses out-of-pocket or wait for reimbursement.<br>▪ When you cannot use the debit card, you should submit a claim to Alight Smart-Choice Accounts™, the claims administrator, for processing and reimbursement from your account. See "How to file a claim" on page F-13 for more information. |

**Use it or lose it!**

You should carefully plan out how much money you want to contribute to your account(s) based on your estimated expenses for the plan year. Any unused contributions over $610 not claimed by March 31 of the following year for eligible expenses incurred by December 31 of the plan year will be forfeited.

## Using the Health Care FSA and Limited Purpose FSA

The Health Care FSA may be used to pay for certain expenses not reimbursed by any other health insurance or coverage.

According to federal guidelines, you cannot open a Health Care FSA if you enroll in a high deductible health plan — you can only be in a Limited Purpose FSA. The Limited Purpose FSA may be used to pay for qualifying out-of-pocket dental and vision expenses. You cannot submit medical or prescription drug expenses to your Limited Purpose FSA for reimbursement until your deductible has been met. Those expenses are eligible for reimbursement from your Health Savings Account (HSA) prior to your deductible being met. See the *Health Savings Account* section for more information.

### Health Care and Limited Purpose FSAs at a glance

The Health Care FSA and Limited Purpose FSA are both used for health care expenses — but there are differences between the two. You can be enrolled in either the Health Care FSA or Limited Purpose FSA, but not both. The following chart illustrates the similarities and differences between the two accounts.

| Question | Health Care FSA | Limited Purpose FSA |
|---|---|---|
| **Who contributes to the account?** | You, on a pre-tax basis. | You, on a pre-tax basis. |
| **What are the 2025 maximum annual contributions?** | $3,300 | $3,300 |
| **What are eligible expenses?** | ▪ Medical<br>▪ Prescription drug<br>▪ Dental<br>▪ Vision<br>*See page F-7 for a list of eligible expenses.* | ▪ Medical (only once deductible has been met)<br>▪ Prescription drug (only once deductible has been met)<br>▪ Dental<br>▪ Vision<br>*See page F-8 for a list of eligible expenses.* |
| **Can I have a Health Savings Account (HSA) in addition to the FSA?** | No | Yes |
| **Do unspent contributions roll over from year to year?** | Up to $660 can rollover into 2026. | Up to $660 can rollover into 2026. |

## Dependent eligibility for the Health Care and Limited Purpose FSAs

You may submit eligible expenses to your Health Care FSA or Limited Purpose FSA for the following people:

- Yourself.
- Your spouse/domestic partner (DP).
- Eligible dependents.

An eligible dependent must be a "qualifying child" or a "qualifying relative" for federal income tax purposes. The table below briefly summarizes requirements for a "qualifying child" and a "qualifying relative."

| Eligible dependents | Qualifying child* | Qualifying relative* |
|---|---|---|
| **Relationship to employee** | Examples include your:<br>▪ Son/daughter<br>▪ Stepchild<br>▪ Child for whom you are the legal guardian<br>▪ Child placed with you for adoption<br>▪ Brother/sister<br>▪ Stepbrother/stepsister<br>▪ Grandchild<br>▪ Nephew/niece<br>The individual cannot be the qualifying child of any other person. | Examples include your:<br>▪ Son/daughter<br>▪ Stepchild<br>▪ Brother/sister<br>▪ Stepbrother/stepsister<br>▪ Grandchild<br>▪ Nephew/niece<br>▪ Parent<br>▪ Grandparent<br>▪ Son-in-law/daughter-in-law<br>The individual cannot be a qualifying relative of any other person. |
| **Residency requirements** | Lives with you for more than half of the year and is a U.S. citizen or national, or a resident of the U.S., Canada or Mexico. | Is a U.S. citizen or national, or a resident of the U.S., Canada or Mexico. |
| **Age requirement** | ▪ The individual must be younger than you and under age 27, regardless of full-time student status; or<br>▪ Any age if permanently and totally disabled. | No requirement applicable. |
| **Support requirement** | You will provide over half of his or her support for the year. | You will provide over half of his or her support for the year. |
| **Income limitations** | No limitation applicable for individual being claimed. If you are not the parent of the qualifying child, your adjusted gross income must be higher than the highest adjusted gross income of any parent of the qualifying child. | Will have gross income for the year of less than the personal exemption amount ($4,700 in 2025). |
| **Joint return limitation** | If married, will not file a joint federal income tax return with his or her spouse/DP. | If married, will not file a joint federal income tax return with his or her spouse/DP. |

** The information provided in the table above does not include all the requirements for a "qualifying child" or a "qualifying relative" for federal income tax purposes. For more information on those requirements, see section 152 of the Internal Revenue Code and IRS Publication 502 which are available on the IRS website at www.irs.gov.*

## Contributions

You may contribute between $100 and $3,300 to a Health Care FSA or Limited Purpose FSA each year. Contributions are deducted from your paycheck on a pre-tax basis in equal installments throughout the year.

## Reimbursements

Upon enrollment in a Health Care or Limited Purpose FSA, you will receive a debit card to pay for qualified expenses at the point of sale up to the amount of your annual election. If the provider cannot accept the debit card, you will need to submit your receipts to Alight Smart-Choice Accounts™ for reimbursement. See "How to file a claim" on page F-13.

✓ You can enroll to have your reimbursements directly deposited into your bank account. If you do not enroll in direct deposit, you will receive reimbursements by check. You can submit eligible expenses for any amount, but Alight Smart-Choice Accounts™ will not issue a check until your eligible expenses accumulate to at least $25. For your final reimbursement of the year, you will be reimbursed for eligible expenses up to the balance left in your FSA, even if it is less than $25.

## Eligible expenses

To be eligible for reimbursement, expenses must be incurred during the plan year that you contribute to the FSA. You can be reimbursed for eligible expenses for yourself and any eligible dependents.

### *Health Care FSA eligible expenses*

Generally, you can use the Health Care FSA to pay for any expenses (other than health insurance premiums) that would be considered tax-deductible medical expenses for federal income tax purposes. Examples of eligible expenses include, but are not limited to:

- Charges paid over the maximum reimbursable charges.
- Expenses in excess of medical, prescription drug, dental, or vision plan limits.
- Medical, dental, and vision insurance plan deductibles, copays and coinsurance.
- Prescription drug copays or coinsurance.

Here is a partial list of specific eligible expenses, as permitted by IRS regulations. This list is not a guarantee of reimbursement. Eligible expenses may change from time to time, so please check with Alight Smart-Choice Accounts™ if you have questions about a specific expense.

- Acupuncture.
- Bandages.
- Birth control, if not fully covered under prescription drug benefits.
- Braille books and magazines.
- Chiropractic expenses.
- Christian Science practitioners.
- Dental treatments.
- Guide dog or other service animal.
- Hearing aids.
- In vitro fertilization.
- Learning disability treatment.
- Nursing home (for medical reasons only).
- Oxygen and oxygen equipment.
- Physical exams, if not fully covered under medical coverage.
- Prescription medicines and drugs.
- Psychoanalysis or other psychiatric care.
- School for someone with a learning disability caused by mental or physical impairments.
- Smoking cessation programs, if not fully covered under prescription drug benefits.
- Special automobile hand controls or other equipment for use by handicapped person.
- Telephone for persons with a hearing or speech disability.
- Vision expenses, such as eye exams, eyeglasses and contact lenses (including related materials like saline solution and enzyme cleaner), and lasik or corrective surgery.
- Vitamins and mineral supplements prescribed for treatment of illness.

✓ For a complete list of eligible and ineligible Health Care FSA expenses, please see IRS publication 502 available on the IRS website at http://www.irs.gov/pub/irs-pdf/p502.pdf.

**Lisa's farsightedness**

Lisa has always had 20/20 vision — or so she thought. So when she found herself having to hold a book further and further away to make the words come into focus, she decided it was time for an eye exam. It turns out that Lisa needed glasses, at least when she was reading.

Lisa was not enrolled in the vision plan, and the eye exam and eyeglasses cost $175. Luckily, Lisa had elected to contribute $500 to her Health Care FSA, so she used her FSA debit card and the expenses were paid right from her account to her provider, allowing her to pay with pre-tax dollars.

### *Limited Purpose FSA eligible expenses*

Generally, out-of-pocket medical and prescription drug expenses must be paid from your Health Savings Account (HSA), which means you can only use your Limited Purpose FSA for dental and vision expenses. Examples of eligible expenses, as permitted by IRS regulations include, but are not limited to:

- Contact lenses and solutions.
- Dental or vision copays, deductibles, and coinsurance.
- Expenses in excess of dental or vision plan limits.
- Eyeglasses or contact lenses.
- Laser eye surgery, lasik, or other treatment to correct vision.
- Orthodontia expenses.
- Prescription sunglasses.
- Qualified dental or vision expenses not otherwise paid by a dental or vision plan.

Your Limited Purpose FSA can be used for eligible medical and prescription drug expenses once your deductible has been met.

## Ineligible expenses

The IRS limits expenses that can be reimbursed from your Health Care FSA or Limited Purpose FSA.

### *Health Care FSA ineligible expenses*

The following are examples of expenses not eligible for reimbursement under the Health Care FSA:

- Cosmetic surgery that is not medically necessary.
- Custodial care in an institution, such as a nursing home.
- Dietary supplements, vitamins, or over-the-counter drugs not prescribed by a physician to treat a specific medical condition.
- Funeral, cremation, or burial expenses.
- Health club dues if not prescribed by a physician as part of a regimen to treat a specific condition.
- Illegal or experimental procedures or medications.
- Marriage or family counseling.
- Medical, dental, vision, life, disability, accident, or automobile insurance premiums.
- Other health care items that are not medically necessary.
- Weight-loss programs, unless prescribed by a physician to treat a medical illness.

### *Limited Purpose FSA ineligible expenses*

The following are examples of expenses not eligible for reimbursement under the Limited Purpose FSA:

- Cosmetic procedures.
- Dental or vision insurance premiums.
- Expenses reimbursed by a dental, vision, or other health insurance plan.
- Illegal, experimental, or investigational procedures or services.
- Medical equipment.
- Medical expenses, including deductibles, copays, and coinsurance.
- Non-prescription sunglasses.
- Over-the-counter medicines and medical supplies.
- Personal use items, such as toothbrushes or toothpaste.
- Prescription drugs.
- Teeth whitening or bleaching.

## Health Care or Limited Purpose FSA vs. income tax deduction

The Health Care FSA or Limited Purpose FSA can save you money on your taxes. Another option is to claim your health care expenses as a deduction on your income tax returns.

- When you contribute to a Health Care FSA or Limited Purpose FSA, you lower the amount of Social Security, Medicare, federal and, in most areas, state and local taxes you pay.
- You may be able to claim tax deductions for your unreimbursed health care expenses. To qualify for this deduction in 2025, your total unreimbursed expenses for the calendar year must be more than 7.5% of your adjusted gross income, and you can only deduct the portion of expenses that exceed 10% of your adjusted gross income.

**You may not deduct expenses on your income tax return that are reimbursed through your Health Care FSA or Limited Purpose FSA.** Most people find the FSA is more advantageous than the income tax deduction for health care expenses. However, you should consult a tax specialist to find out which is best for you.

## Using the Dependent Care FSA

The Dependent Care FSA covers qualifying dependent care expenses paid so that you and your spouse/DP (if married) can work, look for work or attend school full-time.

### Dependent eligibility for the Dependent Care FSA

You may be reimbursed for qualifying dependent care expenses you incur for a spouse/DP, child, or other individual who qualifies as a "qualifying individual" for federal income tax purposes. The table below briefly summarizes requirements for a spouse/DP, child or other individual to be a "qualifying individual."

| Eligible dependent | Spouse/DP | Qualifying child* | Other qualifying individual* |
|---|---|---|---|
| **Relationship to employee** | Your spouse/DP. | Examples include your:<br>▪ Son/daughter<br>▪ Stepchild<br>▪ Child for whom you are the legal guardian<br>▪ Child placed with you for adoption<br>▪ Brother/sister<br>▪ Stepbrother/sister<br>▪ Grandchild<br>▪ Nephew/niece<br>The individual cannot be the qualifying child of any other person. | Examples include your:<br>▪ Son/daughter<br>▪ Stepchild<br>▪ Brother/sister<br>▪ Stepbrother/sister<br>▪ Grandchild<br>▪ Nephew/niece<br>▪ Parent<br>▪ Grandparent<br>▪ Uncle/aunt<br>▪ Son-in-law/daughter-in-law<br>The individual cannot be a qualifying individual of any other person. |
| **Disability criteria** | Is physically or mentally not able to care for himself or herself. | No disability criteria required. | Is physically or mentally not able to care for himself or herself. |
| **Residency requirement** | Lives with you for more than half of the year. | Lives with you for more than half of the year and is a U.S. citizen or national or a resident of the U.S., Canada or Mexico. | Lives with you for more than half of the year and is a U.S. citizen or national or a resident of the U.S., Canada or Mexico. |
| **Age requirement** | None. | Is under the age of 13 when the care is provided. | None. |
| **Support requirement** | None. | If you are not the parent of the qualifying child, your adjusted gross income must be higher than the highest adjusted gross income of any parent of the qualifying child. | You provide over half of his or her support for the year. |

** The information provided in the table above does not include all the requirements for a "qualifying individual" for federal income tax purposes. For more information on those requirements see sections 21 and 152 of the Internal Revenue Code and IRS Publications 503 and 501 which are available on the IRS website at www.irs.gov.*

## Contributions

You may contribute each year to the Dependent Care FSA up to the amounts shown in the table below.

| If you are: | Minimum annual contribution | Maximum annual contribution* |
|---|---|---|
| **Single** | $100 | $5,000 |
| **Married** | $100 | $5,000 if filing a joint tax return<br>$2,500 if filing separate tax returns |

** The amount you elect for 2025 could be decreased midyear if the Company thinks the plan is going to fail IRS discrimination testing to avoid returning any monies and any penalties for you as a participating employee.*

Contributions are deducted from your paycheck on a pre-tax basis in equal installments throughout the year. If your goal amount is not equally divisible by the number of pay periods, your actual contributions may be slightly different than your goal amount.

## Reimbursements

You may be reimbursed only up to the amount of your current Dependent Care FSA account balance. If your claim exceeds the amount of money you have contributed so far to your account, the unpaid balance will be paid once additional contributions have been deducted from your pay. Reimbursements are not subject to tax.

## Eligible expenses

To qualify, expenses must be for care that allows you and your spouse/DP to work, look for work, or attend school full-time. Care may be given in either a private home (including yours) or in a day care center. To be eligible for reimbursement, expenses must be incurred during the calendar year for which contributions have been made to your Dependent Care FSA.

### Dependent Care FSA eligible expenses

Some examples of eligible, reimbursable dependent care expenses include, but are not limited to:

- A qualified day care center, nursery school, or summer day camp.
- A housekeeper whose duties include day care (limited to the portion spent on day care which allows you and your spouse/DP to work, look for work, or attend school full-time).
- Someone who cares for an elderly or incapacitated dependent.
- A babysitter inside or outside your home.
- A relative who cares for your dependents, as long as that relative is not one of your dependents for whom you can claim a tax exemption or one of your children under age 19.

Remember, you will need to provide a tax ID number or the Social Security number of the care provider when you fill out your reimbursement request.

## Ineligible expenses

Expenses that are not eligible for reimbursement from your dependent care account include, but are not limited to:

- Child support payments.
- Costs paid to your own dependent under age 19, or to anyone you claim as a dependent for federal income tax purposes, who is caring for your dependents.
- Day care for a child age 13 or older (unless the child is disabled).
- Expenses for care received before you were covered by the Dependent Care FSA (or before or after your participation in the current plan year).
- Expenses for which you claim a dependent day care tax credit on your federal income tax return.
- Housekeeping expenses not related to dependent day care or expenses not for care, such as food, lodging, clothing, education, and entertainment. These items may only be eligible if they are incidental to and cannot be separated from the cost of care.
- Kindergarten or school tuition for a child age five or older.
- Nighttime babysitting expenses that are not work-related.
- Overnight summer camp (cannot prorate for the day portion).
- Registration fees paid for day care, summer camp, kindergarten, preschool, etc. The only exception is day camp or registration fees applied toward the first payable bill. These are eligible once the initial bill has been paid and the service has been provided.
- Twenty-four hour custodial care in a nursing home.

✓ For a complete list of eligible and ineligible dependent care account expenses, see *IRS Publication 503 — Child and Dependent Care expenses* at https://www.irs.gov/pub/irs-pdf/p503.pdf.

**Take a quiz about eligible expenses under the Dependent Care FSA**

Which of the following expenses are eligible for reimbursement under the dependent care account?

- Nate and his wife both work full-time. They do not have any kids, but Nate's mom lives with them year-round and is unable to care for herself during the day while they are at work. An adult day care worker comes into their home to help with his mom. Are those expenses reimbursable?

  *Yes. Nate's mom qualifies as a dependent and the expenses are incurred while he and his wife are both working.*

- Cindy's husband lost his job last year. Luckily, Cindy is working but they pay a large tuition bill each month with their 9-year-old twins enrolled in a private elementary school. Cindy's husband is looking for work, so is their kids' tuition eligible for reimbursement?

  *No. Even though her husband is looking for work, school tuition for children age five or older is not an eligible expense.*

- Jerry and his wife, Kathy, have a nanny who comes to their house to watch their daughter while they go to work. They occasionally have their nanny babysit for them after hours (and pay her extra) so they can go out to eat or to a movie. Is their nanny's salary reimbursable under the dependent care account?

  *Yes and no. The amount they pay their nanny to watch their daughter while they are working is eligible. But the extra amount they pay the nanny for after-hours care while they are not working is not eligible.*

## Dependent Care FSA vs. income tax credit

The Dependent Care FSA can save you money on your taxes — or you may take a tax credit for your eligible dependent care expenses. You may also be able to use the Dependent Care FSA for a portion of your dependent care expenses and then take the tax credit for the remaining amount. The method that is best for you depends upon your individual situation.

In some cases, using the Dependent Care FSA can save you more. In other cases, you may save more by taking a credit on your federal income tax return. Tax laws do change from year to year, and you should consult a tax specialist to determine which approach is best for you.

**Smart-Choice Mobile App**

You can manage your FSA information right from your mobile phone. Go to the App Store or Google Play™ to download the Smart-Choice Mobile App, which allows you to:

- Check your account balance anytime.
- View FSA activity.
- Contact customer service.
- Upload receipts.

## How to file a claim

✓ In general, a health care or dependent care expense is considered incurred when you or your dependents receive the care or service, not when you are billed for it or pay for it.

Expenses can be reimbursed from the FSAs if services are incurred while you are a participant in the plan.

A claim will be reimbursed only if the expense was incurred in the same calendar year in which the contribution to the FSA was made. So you can use your 2025 FSA contributions only for eligible expenses incurred in 2025. However, at the end of each calendar year, you will have until March 31 of the following year to submit claims for eligible expenses. For example, you may submit claims for expenses incurred during 2025 until March 31, 2026. After March 31, any money contributed in the previous year that has not been claimed will be forfeited.

### FSA debit card

When you enroll in an FSA, you will receive a special debit card to handle your account transactions. When you use the debit card, you will not have to pay out-of-pocket for expenses or wait for reimbursements. Just use the card to pay for services or expenses as you incur them, and the amount will be paid directly to the provider, until your account is exhausted. Please refer to the following sections for more information on substantiating claims.

- You will be issued one FSA debit card in your name when you enroll. You and your eligible dependents can use the card to pay eligible expenses.
- The FSA debit card is automatically activated with the first use.
- When using the FSA debit card, if you have not assigned a PIN to your card, select "credit" at the point-of-sale. If you have assigned a PIN to your card, select "debit" and enter your PIN.
- FSA debit cards are valid for three years (as long as you remain eligible and enrolled in a Health Care FSA, Limited Purpose FSA, or Dependent Care FSA).
- Request additional or replacement debit cards online at digital.alight.com/aptim or call 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT.

#### *Using the card*

The FSA debit card is primarily used for eligible health care expenses, but may be used at certain day care facilities if the merchant is coded as an approved day care facility. Contact Alight Smart-Choice Accounts™ for information about how to use the card for eligible Dependent Care FSA expenses.

The FSA debit card will work at most health care-related merchants, including doctor and dentist offices, and most pharmacies, grocery stores, and discount retailers that are "IIAS compliant."

**What is "IIAS compliant"?**

Many retailers maintain an inventory control system that limits FSA debit card transactions to FSA-eligible items. These retailers are Inventory Information Approval System (IIAS) compliant, and transactions at these locations will not require documentation. They include stores such as CVS, Walgreens, Walmart, and Target. You can find a complete list of IIAS compliant merchants on the Alight Smart-Choice Accounts™ website at digital.alight.com/aptim.

When you use your debit card at these locations, you can swipe your card for your entire purchase. Items that are eligible Health Care FSA expenses will be automatically processed, and you must pay the merchant for any ineligible items. It is always a good idea to save your receipts, even if you use the debit card to pay for eligible expenses. In some instances, you may be required to submit additional documentation to substantiate debit card transactions. You can upload the documentation online or submit it by fax or mail.

### *When documentation is not needed*

Debit card transactions will be automatically substantiated without additional paperwork if they are:

- Health care coverage copays (including eligible medical, prescription drugs, dental, or vision).
- Recurring transactions that match the provider and dollar amount exactly for previously approved transactions (for example, orthodontia claims or maintenance prescription drugs) and that you noted as "recurring" on a previous request for substantiation or the "Receipt and Substantiation" form.
- Purchases made at IIAS-compliant merchants.

### *When documentation is needed*

Debit card transactions that do not meet the criteria listed above will need additional documentation to be substantiated. (For a list of acceptable documentation, see "Submitting electronic claims" below.) In these cases:

- You will receive automated email reminders until you provide the correct documentation. If Alight Smart-Choice Accounts™ does not have your email address, you will receive a letter by mail.
- If documentation has not been received and processed within 72 days of the debit card transaction, your debit card will be temporarily deactivated until you either:
  - Pay the unsubstantiated amount back into your FSA via payment to Alight Smart-Choice Accounts™; or
  - Offset the ineligible amount with documentation for other eligible expenses incurred within the same plan year.

  Your FSA debit card will be reactivated when the appropriate documentation or repayment is received.

**Note:** The debit card may be turned off if you do not provide proof, such as a receipt or an invoice, when requested, for transactions that cannot be verified electronically. In addition, you will have to pay the plan back for any unsubstantiated expenses.

## Submitting electronic claims

The debit card may not be accepted by all service providers. In that case, or if you prefer not to use the debit card, you may submit your claims for reimbursement to Smart-Choice online at digital.alight.com/aptim, or through the Smart-Choice mobile app, along with acceptable documentation. Online, you can find "Submit Claim" under the "Take Action" section after clicking the Home icon. Mobile App, you can find "Submit Claim" after clicking the Home icon. For more information, go to digital.alight.com/aptim and click on your FSA account button or call 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT.

The IRS requires that the following information is included with your claims:

| Information required to be submitted with FSA claims | |
|---|---|
| **Health Care FSA or Limited Purpose FSA** | **Dependent Care FSA** |
| ▪ Date the service was received or date purchase was made.<br>▪ Description of the service or item purchased.<br>▪ Dollar amount.<br>▪ Provider name.<br>▪ Prescription drug number and name (if applicable). | ▪ Dates of service.<br>▪ Day care provider name.<br>▪ Day care provider signature.<br>▪ Day care provider Tax ID or Social Security number.<br>▪ Dollar amount incurred. |

### Account summary

You can check your account summary, including balance, claim status, and transaction history, through the Smart-Choice mobile app or the APTIM Benefits Marketplace online at digital.alight.com/aptim or call 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT.

## Changing your elections

IRS regulations do not permit you to stop or change the amount you contribute to a Flexible Spending Account during the calendar year unless you meet one of the qualifying life event conditions in the table below. These rules are intended to be consistent with the IRS regulations under Sections 125 and 129 of the Internal Revenue Code, and to the extent there is any inconsistency, those regulations shall control.

| You can make certain FSA contribution changes during the year if one of these qualifying life events occurs. | | |
|---|---|---|
| **For the Health Care FSA, the Limited Purpose FSA and the Dependent Care FSA:** | **In addition, for the Health Care FSA and the Limited Purpose FSA:** | **In addition, for the Dependent Care FSA:** |
| ▪ **Changes in legal marital status.** Events include marriage, death of your spouse/DP, divorce, legal separation, or annulment.<br>▪ **Changes in the number of your dependents.** Events include birth, adoption, placement for adoption, or death of a dependent.<br>▪ **Changes in employment status.** Events include start or termination of employment or another change in the employment status of you, your spouse/DP or your dependent.<br>▪ **Changes in dependent eligibility.** Events include a change in age, financial support or residency, as provided under the Health Care FSA, Limited Purpose FSA or Dependent Care FSA eligibility rules. | ▪ **Becoming eligible or ineligible for Medicare or Medicaid.**<br>▪ **Court order.** A judgment, decree or order in a divorce, legal separation, annulment, or change in legal custody that requires:<br>– You to provide health care coverage for your dependent child; or<br>– That your former spouse/DP provides health care coverage and that coverage is provided. | ▪ **A significant increase or decrease in the cost of the dependent care.** This only applies if the dependent care provider that imposes the cost change is not related to you. |

To request a change in your contribution amount, **you must make benefit changes within 31 days of the qualifying life event.** No election changes will be permitted after 31 days. You can make changes via the APTIM Benefits Marketplace at digital.alight.com/aptim or call 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT. Please note that you will be required to provide documentation to complete any changes to your FSA elections.

Any change you make to your FSA election due to a qualifying life event must be consistent with, or correspond to, how the event affects eligibility for coverage. This means that there must be a logical relationship between the event that occurs and the election change you are requesting. For example, if you have a baby, you may increase your Health Care FSA election to reflect your new child's eligibility for coverage, but you may not decrease or stop your Health Care FSA coverage.

Changes in contribution amounts made during the plan year are effective retroactive to the date of the event. The per-pay-period deductions will be calculated based on the pay periods remaining in the year.

## FSA rules and other limitations

There are a couple of important rules you should keep in mind regarding your FSAs.

### No transfers

You may not transfer money between your Health Care FSA or Limited Purpose FSA and your Dependent Care FSA, even if you have extra money in one of the accounts at the end of the year. For example, suppose you elect to contribute $400 to your Health Care FSA and $400 to your Dependent Care FSA for the year (for a total of $800), and by the end of the calendar year you have incurred $200 in eligible health care expenses and $600 in eligible dependent care expenses.

- The $200 of health care expenses would be reimbursed from your Health Care FSA.
- You would receive reimbursement for only $400 of the dependent care expenses from your Dependent Care FSA.
- The other $200 of dependent care expenses would not be reimbursed, and you would have to forfeit the remaining $200 in your Health Care FSA after the end of the calendar year.

### Forfeitures

If you do not incur eligible expenses during the calendar year for all of the money in your FSA(s) — and file claims for reimbursement of all of the money in your account(s) by March 31 of the following year — you will lose any money left in your account(s). Therefore, careful planning is important when deciding how much you want to put into each account.

### Plan year closing

Alight Smart-Choice Accounts™ performs an FSA plan closing process following the end of each plan year. During plan closing, Alight Smart-Choice Accounts™ reviews all FSA account credits, debits and repayments and ensures that the plan complies with IRS regulations. Plan closing occurs shortly after the March 31 deadline for filing claims.

You may receive a notice during and/or following the end of the plan year that you have unsubstantiated claims from your FSA. These are typically for expenses paid using your FSA debit card. You must provide documentation to substantiate those claims (for example, a receipt, bill/statement or explanation of benefits). If you do not substantiate the claims, they become taxable and will be subtracted from your pay on an after-tax basis and returned to the plan to offset plan expenses after the plan year closing.

## What if I go on a leave of absence?

You may be eligible to continue FSA contributions and reimbursements during your leave of absence. See "Can I continue coverage during a leave of absence?" on page A-14 of the *General Information* section for details.

### Uniformed Services Employment and Reemployment Rights Act

If you are absent from employment for more than 30 days by reason of service in the Uniformed Services, you may elect to continue Health Care FSA or Limited Purpose FSA coverage for yourself and your dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). For additional information regarding your rights under USERRA, please refer to the *Benefit Rights* section.

## When coverage ends

Your coverage ends on the date your employment with the Company ends or after six months of being on a leave of absence. See "When does coverage end?" in the *General Information* section for more information. If you leave APTIM, you will have 90 days from your termination date to submit claims for reimbursement. Your claims must be for qualifying expenses incurred through your date of termination of employment.

### Continuing your Health Care FSA or Limited Purpose FSA

If you terminate employment and would like to continue participating in the Health Care FSA or Limited Purpose FSA to avoid forfeiting any funds remaining in your account, you may do so through COBRA coverage until the end of the plan year.

- The amounts you pay to continue coverage must be less than the remaining benefits you can receive under the Health Care FSA or Limited Purpose FSA.
- Contributions for continuation of coverage will be on an after-tax basis and will include a 2% administration fee.
- Participation in a Health Care FSA or Limited Purpose FSA cannot continue past the end of the year in which your employment terminates.

**Nathan elects Health Care FSA COBRA coverage**

Nathan elected an annual contribution of $1,200 to the Health Care FSA. When he terminated his employment on June 30, he had contributed $600 to his account, but had only incurred $200 in eligible expenses for the plan year.

To avoid forfeiting the $400 he had already contributed to the Health Care FSA but had not yet been reimbursed, Nathan elected to continue his Health Care FSA through COBRA coverage. He will contribute an additional $600 (plus a 2% administrative fee) on an after-tax basis through December 31 of this year. As he incurs eligible expenses until the end of the plan year, Nathan will receive reimbursement of the remaining $1,000 from his Health Care FSA.

See "COBRA continuation coverage" in the *Benefit Rights* section for additional details. If you do not elect to continue participation under COBRA, you may only submit claims for reimbursement of eligible health care expenses incurred through your date of termination.

### Continuing your Dependent Care FSA

You may not continue participating in the Dependent Care FSA under COBRA. You can make claims for reimbursement of eligible dependent care expenses incurred through your date of termination.

# Commuter Benefit



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

## Your Commuter Benefit

The Commuter Benefit, provided by Alight Smart-Choice Accounts™, allows you to pay for certain work-related transportation expenses, such as parking, transit, and biking, via convenient pre-tax payroll deductions on a per-pay-period basis. You can contribute up to $325 a month for transit and $325 a month for parking on a pre-tax basis, but you must enroll by the 10th of each month. You may also add up to $20 to your paycheck as taxable income for a biking maintenance benefit.

## Eligibility

You are eligible for the Commuter Benefit if you are a regular full-time or regular part-time employee of APTIM, and you work at an APTIM office or project site in the continental U.S. See the *General Information* section starting on page A-1 for more information about eligibility and enrollment.

## What is covered

Commuter Benefit eligible expenses include transportation via the following:

- Train.
- Bus.
- Subway.
- Ferry.
- Parking.
- Bike maintenance.

## Using your benefit

Participants will receive a benefits debit card from Alight Smart-Choice Accounts™ that they can use to pay providers at the time of service directly from their transit account. The card will only work at merchants that have a debit card merchant category code of Mass Transit.

## Reimbursement

Transit receipts may be required by Alight Smart-Choice Accounts™ to reimburse claims. It is recommended that you keep receipts for your own records, as well.

## How to enroll

To enroll, visit the APTIM Benefits Marketplace at digital.alight.com/aptim or contact Alight Smart-Choice Accounts™ at 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT., and follow the prompts. You must enroll by the 10th of each month. Enrollments are effective the 1st of the following month.

# Employee Assistance Program (EAP)



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

## Your EAP coverage

Many of us face challenging personal and work-related issues at some point in our lives. That is why the Company provides the Employee Assistance Program (EAP), which is administered by ComPsych GuidanceResources Worldwide, at no cost to you. The EAP can help when those issues become too difficult to handle on your own.

The program provides free, confidential assistance to you and members of your household. Services are available regardless of whether or not you are enrolled in the Medical Plan.

Please note that all requests and services received through the EAP are confidential. The EAP provider will not share your information with the Company without your permission or unless required by law (e.g., for child or elder abuse, or in a life-threatening situation).

**Who is considered a member of my household?**

Eligibility for EAP services is much broader than it is for other benefits. It includes you and members of your household, which consists of:

- Anyone who physically resides in your home on a permanent basis; or
- Your unmarried dependent child(ren), whether or not they live with you.

## What does coverage cost?

The Company pays the full cost of your EAP coverage. You do not have to pay any premiums, copays, coinsurance or deductibles to receive EAP services. ComPsych pays EAP counselors directly, so you should not make any payments or payment agreements with EAP providers.

However, you are responsible for paying for EAP services if you do not:

- Contact ComPsych so they can refer you to an EAP counselor; or
- Complete an EAP authorization after choosing a provider through https://www.guidanceresources.com/groWeb/login/login.xhtml.

## How the EAP works

If you find you need help dealing with an issue that is affecting your personal and/or work life, call the EAP. Personal advocates are available 24 hours a day, 365 days a year. They offer assessment and referral services, as well as short-term counseling when appropriate.

Please note that the EAP covers up to five face-to-face counseling sessions per issue per year. If you require more than five sessions, the additional visits may be covered under your medical coverage. You will need to check with your selected carrier to determine coverage.

**How can I reach the EAP?**

- By phone at 1-866-207-5157 or 1-866-641-3847 (Canada).
- Online at https://www.guidanceresources.com/groWeb/login/login.xhtml. To log in to the website, the Web ID is APTIM.

### What can the EAP help with?

EAP counselors are experienced at helping with a broad range of issues. These are just a few:

| Health and wellness | Legal and financial issues | Family issues | Life at Work |
|---|---|---|---|
| ▪ Stress management | ▪ Personal injury | ▪ Child care | ▪ Work/life balance |
| ▪ Grief and loss | ▪ Estate planning | ▪ Senior care | ▪ Working overtime |
| ▪ Mental health | ▪ Family law | ▪ Family and marital problems | ▪ Workplace conflict |
| ▪ Eating disorders | ▪ Financial planning | ▪ Learning disorders | ▪ Working with others |
| ▪ Sleep disorders | ▪ Identity theft | ▪ Pet care | |
| ▪ Substance abuse | ▪ Debt consolidation | | |

**Nancy needs a nanny**

Nancy's maternity leave begins in just two days. She is planning to return to work when the leave is up, but she just received the disappointing news that the nanny she had lined up will not be available soon enough. In a panic, Nancy calls the EAP for help. They provide her with referrals to daycare centers and nannies near her home, as well as helpful interviewing tips.

Three months later, Nancy is back at work. She was able to secure a highly recommended nanny right before giving birth to a healthy baby girl!

### Behavioral Telehealth

Behavioral Telehealth provides you with access to video-based services for quality care from a licensed provider and is available as part of your EAP benefits. Telehealth services can be used for diagnosis and treatment of behavioral health issues such as:

- Anxiety
- Depression
- Family and relationship issues
- Grief
- Stress
- Substance use

To use, simply go to https://www.guidanceresources.com/groWeb/login/login.xhtml to search for a video telehealth provider in the ComPsych network by specialty. Then call to make an appointment with your selected provider, just like you would for a face-to-face visit. The provider will give you information on how to set up the video-based session according to the technology they are using. Costs are the same as an in-office visit.

## What services are provided?

The EAP offers counseling, discounts, resources, and referrals to help employees tackle tough personal, relationship, and work-related issues.

| EAP services | Details |
|---|---|
| **Professional counseling** | |
| **Face-to-face counseling** | Up to five sessions per issue per year with a licensed counselor in your area. |
| **Phone consultation** | A behavioral health professional works with you to:<br>▪ Identify and assess your problem.<br>▪ Develop an action plan.<br>▪ Suggest appropriate referrals. |
| **Online information** | |
| **Provider directory** | ▪ Determine what kind of professional provider you need.<br>▪ Generate a list of providers based on location and other search criteria. |
| **Article library with hundreds of topics (mental health, legal, medical, financial, educational, etc.)** | Find articles on your topic of interest. |
| **Self-assessment tool** | Get feedback, suggestions and self-help resources. |
| **Click-to-chat feature** | ▪ A convenient way to access EAP benefits online quickly and easily at https://www.guidanceresources.com/groWeb/login/login.xhtml (log in with APTIM as the Web ID).<br>▪ Chat live (instant message) with a trained clinician about work/life concerns.<br>▪ Provides another channel for obtaining EAP authorizations, as well as clinical and non-clinical referrals.<br>▪ Available Monday through Friday, 8 a.m. to 4 p.m. Central time. |
| **Discounts** | |
| **Financial assistance*** | Free half-hour telephonic session with a financial advisor. |
| ***Healthy Rewards* program** | Discounts on a wide range of complementary health care products and services, including:<br>▪ Acupuncture.<br>▪ Chiropractic care.<br>▪ Massage therapy.<br>▪ Vision and hearing care.<br>▪ Vitamin and herbal supplements.<br>▪ Fitness club memberships. |
| **Identity theft*** | Free 60-minute consultation with a fraud resolution specialist. |
| **Legal assistance*** | Free half-hour telephonic or discounted face-to-face meeting with an attorney. |

** Limited to one session per issue, per year.*

**Take an EAP quiz!**

- John's daughter recently graduated from college and moved back home with John and his wife. Can his daughter call the EAP for money management help?

  *Yes. All members of your household qualify for EAP services.*

- Pam thinks she may have a drinking problem. She wants to contact the EAP for help, but she is afraid of her manager finding out. Should she be concerned about this?

  *No. All requests and services are confidential. ComPsych does not tell the Company who used the EAP.*

- Steve wants to talk to an EAP counselor about his weight problem, but he did not enroll in the Medical Plan. Is he eligible?

  *Yes. Employees do not have to participate in the Medical Plan to qualify for EAP benefits.*

- Earlier in the year, Ellen received five counseling sessions through the EAP to learn how to manage her stress. Now she would like to see a counselor again to discuss a current relationship issue. Is she eligible for more face-to-face counseling through the EAP?

  *Yes. The EAP covers five sessions **per issue per year**, not five total visits per year.*

## What is not covered?

The EAP does not cover the following services or charges:

- Acupuncture (may be eligible for discounted acupuncture through the *Healthy Rewards* program).
- Aversion therapy.
- Biofeedback or hypnotherapy.
- Counseling, evaluation or preparation of recommendations for use in legal actions of any kind, or required by any governmental agency, including, but not limited to:
  - Child custody or abuse proceedings.
  - Criminal proceedings.
  - Workers' compensation proceedings.
- Direct treatment for mental retardation, learning disabilities, or autism.
- EAP counseling sessions that were not accessed through ComPsych (either by phone or the online self-referral service) for the particular problem.
- Evaluations for fitness for duty determinations or excuses for leaves of absence or time off.
- Examinations and diagnostic services in connection with:
  - Admission to or continuing in school.
  - Obtaining any kind of insurance coverage.
  - Obtaining employment or a particular employment assignment.
  - Securing any kind of license (including professional licenses).
- Experimental or investigational treatments, procedures or devices, as determined by ComPsych.
- Guidance on suing the Company.
- Inpatient treatment.

- Legal assistance for the following:
  - Commercial enterprise.
  - Employment issues.
  - Matters considered frivolous or harassing by the consulting attorney.
  - Matters involving a violation of ethics rules.
  - Matters involving ComPsych, APTIM, the legal services vendor or its plan attorney.
  - Second opinions or third-party advice (such as a relative's legal problem).
- Medication for or treatment of any condition for which medication is required, unless you are seeing a doctor who prescribes and oversees your use of medication for that condition.
- More than five in-person EAP counseling sessions per issue per year.
- Psychiatric services or similar medical care, including services for a condition that requires psychiatric treatment (for example, a psychosis), and prescription drugs.
- Psychological, psychiatric, neurological, educational or IQ testing.
- Recommendation or endorsement of an attorney to represent you. *This decision can only be made by you.*
- Remedial and social skills education services, such as:
  - Behavioral training.
  - Cognitive rehabilitation.
  - Evaluation or treatment of academic skill disorders, communication disorders, language disorders, learning disabilities or disorders, mental retardation, or motor skill disorders.
- Services by providers who are not part of ComPsych's EAP counselor network.
- Services or supplies not needed for treatment or not approved by your EAP counselor.
- Services or supplies rendered by a family member, whether or not there is a charge for it.
- Services rendered before coverage became effective or after coverage ends.
- Sleep therapy.
- Testimony, creation of records or other preparation for legal proceedings.
- Treatment for any physical illness.
- Treatment for any problem or condition that cannot be resolved in brief counseling (for example, a condition that requires inpatient treatment or more than five outpatient sessions).

# Life Insurance Plan



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

## Your life insurance coverage

Life insurance provides financial security to your beneficiaries in the event of your death. Your coverage consists of:

- Basic Company-paid life insurance; and
- Optional employee-paid life insurance.

Coverage is provided through Prudential.

## How the Life Insurance Plan works

Upon gaining eligibility, you are automatically enrolled in Basic Life Insurance coverage as long as you are actively at work on the day coverage is scheduled to begin. If you wish to elect optional life insurance, you must enroll in that coverage — available for you, your spouse/domestic partner (DP), and your dependent children — and pay the premiums through after-tax payroll deductions. For details on when your coverage is effective, see "When does coverage begin?" in the *General Information* section.

You can enroll in optional life insurance coverage during your new hire enrollment period or during annual benefits open enrollment online through the APTIM Benefits Marketplace website at digital.alight.com/aptim or by calling 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT. Optional life insurance for you and your spouse/DP that is above the guaranteed coverage amount will not be effective until Prudential approves your application for insurance.

✓ Even if you do not elect optional coverage, you should designate a beneficiary for your basic life coverage. You can designate beneficiaries online via the APTIM Benefits Marketplace website at digital.alight.com/aptim or by calling 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT.

**Important note about effective date of coverage**

If you are not actively at work on the date your basic or optional life coverage would otherwise become effective, it will be effective the date you return to active service. This also applies to any future increases in your life insurance. If you are not actively at work on the day that an increase would take effect, it will take effect on the day you return to active service.

If your eligible spouse/DP or dependent child is hospital- or home-confined for medical care or treatment on the date his or her optional life coverage would otherwise be effective, coverage will be effective on the date he or she is no longer hospital- or home-confined.

## Basic Company-paid life insurance

The Company automatically provides basic life insurance coverage at no cost to you. Your basic coverage is equal to one times your current annual base pay rounded to the next higher $1,000, if not already a multiple of $1,000. The maximum coverage amount is $750,000. **Please note:** If your basic life insurance coverage is greater than $50,000, the value of your Company-paid coverage in excess of $50,000 is considered "imputed income" and is subject to income tax, which is taken on a per-pay-period basis. Imputed income is added to your total compensation reported to the Internal Revenue Service (IRS), appears on your W-2 statement and is taxable at your regular income tax rate.

**Using annual base pay to calculate coverage amounts**

Annual base pay is your annual base salary, not including any bonuses, commissions, overtime pay or other extra compensation. For purposes of calculating your basic and optional life insurance coverage amounts, annual base pay is determined as of the November 1st of the plan year immediately prior to the date of a covered loss or your date of hire, whichever is later. Coverage increases due to changes in your annual base pay are effective each January 1st, not throughout the year. All coverage increases are subject to the requirement that you are actively at work on the day the increase takes effect.

## Optional employee-paid life insurance

You can elect optional life insurance coverage for yourself and your eligible dependents in the following amounts:

| Optional life insurance for: | Benefit amount: |
|---|---|
| **Employee** | You can elect up to five times your current annual base pay, up to a maximum of $2,000,000.<br>Guaranteed Issue (GI) is the lesser of three times your base pay or $750,000. You can elect up to the GI amount without having to complete Evidence of Insurability (EOI). |
| **Spouse/DP** | Purchase up to 100% of optional employee life insurance amount in increments of $5,000, up to a maximum of $100,000.<br>Guaranteed Issue (GI) is $25,000. You can elect up to the GI amount without having to complete Evidence of Insurability (EOI).<br>*In order to purchase spouse/DP life insurance, you must have optional employee life insurance and your spouse's/DP's amount cannot exceed yours.* |
| **Dependent child(ren)** | ▪ $5,000 or $10,000 per child. |

### *Guaranteed coverage amount*

During your initial eligibility period, you may elect coverage for yourself and your spouse/DP *up to the guaranteed coverage amount* without providing Evidence of Insurability (EOI). You will be required to provide an EOI if you apply for coverage for yourself and/or your spouse/DP that is greater than the guaranteed coverage amount. Your coverage is pending until the EOI is completed and approved. For the guaranteed coverage amounts, see "Optional employee life" and "Spouse/domestic partner (DP) life" on the next page.

✓ After your initial eligibility period, you can make changes to your optional life insurance coverage if you have a qualifying life event via the APTIM Benefits Marketplace website at digital.alight.com/aptim or by calling 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT. However, any election to increase your coverage made after your initial eligibility period will require Evidence of Insurability (EOI). Your coverage is pending until the EOI is completed and approved. The effective date of any coverage change is the date Prudential decides the EOI is satisfactory and your spouse/DP is not home- or hospital-confined for medical care or treatment.

### *Evidence of Insurability (EOI)*

If you or your spouse/DP are required to provide Evidence of Insurability (EOI), you will be able to complete the EOI process after you enroll.

Until a decision is made, you and/or your spouse/DP will be covered at the guaranteed coverage amount. If the EOI is approved, the optional employee life and/or spouse/DP life insurance coverage will become effective on the day the EOI decision is made, or according to plan rules, as long as you remain eligible and are actively at work.

If any medical exams or tests are required to complete the EOI process, Prudential will arrange for the needed services at no cost to you.

If you or your spouse/DP are required to provide an EOI, you will need to complete the Prudential EOI form available on digital.alight.com/aptim in the Document Library and mail to Prudential.

### *Optional employee life*

You can elect optional life insurance coverage for yourself equal to one, two, three, four, or five times your current annual base pay rounded to the next higher $1,000, if not already a multiple of $1,000. The maximum amount of coverage is $2,000,000. The guaranteed coverage amount for you is the lesser of:

- Three times your current annual base pay (if elected during the initial eligibility period); or
- $750,000.

**Erica's election**

Erica's current annual base pay is $51,200. During her initial eligibility period, she enrolled in optional employee life coverage of four times her annual base pay. Since Erica's election is greater than the guaranteed coverage amount, she will have to provide Evidence of Insurability (EOI) to Prudential. Until her EOI is approved, Erica will have the guaranteed coverage amount of three times her annual base pay.

If approved for four times coverage, Erica's optional employee life insurance amount will be $205,000 calculated as follows:

$51,200 x 4 = $204,800, rounded to the next higher $1,000 = $205,000

### *Spouse/domestic partner (DP) life*

✓ **Note:** If your spouse/DP is no longer eligible for coverage (for example, if you get divorced), it is your responsibility to contact the APTIM Benefits Marketplace by calling 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT, or visit digital.alight.com/aptim to cancel spouse/DP life coverage.

You may elect coverage for your spouse/DP in increments of $5,000 with the maximum amount being the lesser of:

- 100% of your combined employee basic and optional life insurance amounts; or
- $100,000.

During your spouse's/DP's initial eligibility period, you may elect coverage for your spouse/DP up to the guaranteed coverage amount without providing an EOI. The guaranteed coverage amount for your spouse/DP is $25,000. Your spouse/DP will be required to provide an EOI if he or she applies for coverage greater than the guaranteed coverage amount.

After your spouse's/DP's initial eligibility period, he or she can make changes to spouse/DP life coverage if you have a qualifying life event by visiting the APTIM Benefits Marketplace website at digital.alight.com/aptim or by calling 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT. However, any election to increase your spouse's/DP's coverage made after the initial eligibility period will require an EOI. The effective date of any coverage change is the date Prudential decides the EOI is satisfactory and your spouse/DP is not home- or hospital-confined for medical care or treatment.

**Carmen's coverage**

Bill, an APTIM employee, elected optional employee life coverage of one times his current annual base pay of $33,400. He also wants to elect spouse/DP life coverage for his wife, Carmen. What is the highest amount of spouse/DP life coverage he can choose? To figure that out:

- First, he calculated his optional employee life coverage. Bill's coverage is $34,000 ($33,400 x 1, rounded to the next higher $1,000).
- Second, he calculated his basic coverage. Bill's coverage is $34,000 (33,400 x 1, rounded to the next higher $1,000).
- His combined optional and basic employee life coverage is $68,000. However, spouse/DP life coverage is only available in $5,000 increments and cannot be more than 100% of his combined optional and basic employee life coverage. Therefore, the maximum possible spouse/DP life coverage for Carmen is $65,000.

If Bill applies for $65,000 in spouse/DP life coverage for Carmen during her initial eligibility period, she will have to provide Evidence of Insurability (EOI) to Prudential since it exceeds the $25,000 guaranteed coverage amount.

### *Dependent child(ren) life*

You may elect coverage for your dependent children under age 26 (or 26 or older if they are disabled — see the *General Information* section for details on eligible dependents). The coverage amount is:

| Child's age | Life insurance coverage amount |
|---|---|
| **Children — live birth up to age 26** | $5,000 or $10,000 |

The guaranteed coverage amount for your dependent child(ren) is $10,000. An EOI is not required for dependent child(ren) coverage. **You pay one contribution per pay period for all of your eligible children, regardless of the number of children you have.**

✓ It is your responsibility to contact the APTIM Benefits Marketplace by calling 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT, or visit digital.alight.com/aptim to cancel coverage for your dependent children when they are no longer eligible for coverage under the Life Insurance Plan.

**If both you and your spouse/DP work for the Company**

One person may not be covered as both an employee and a spouse/DP under the optional life policy.
If both you and your spouse/DP work for the Company and you both want optional life insurance coverage:

- You can elect optional employee life insurance for yourself and cover your spouse/DP under spouse/DP life insurance (or your spouse/DP can elect optional employee life insurance and cover you under spouse/DP life insurance); or
- You can each enroll in optional life insurance as employees.

Your eligible dependent children can have dependent child life insurance through either you or your spouse/DP, but not both.

# Other plan features

## Suicide exclusion

Your optional life insurance (including dependent life coverage) will not pay benefits if your or your covered dependents' death results from or is caused by suicide, while sane or insane:

- A death benefit is not payable if your or your covered dependents' death results from or is caused by suicide within two years of the date you or your dependents became a covered person. But, Prudential will refund any premiums paid for under this coverage.
- The amount of any increase in your death benefit is not payable if your or your covered dependents' death results from or is caused by suicide within two years of the date of the increase. But, Prudential will refund any premiums paid for that increase.

If your dependent child commits suicide and is survived by other covered dependent children, premiums for the dependent child will not be refunded.

## If you become terminally ill

If you become terminally ill while covered under the Life Insurance Plan, the plan offers an accelerated benefit. Subject to approval by Prudential, the terminally ill insured person can receive up to 90%* (combined but not to exceed $375,000) of his or her life insurance benefit (basic and optional) before death, to help with expenses.

** The maximum percentage in Illinois is 75%.*

### *Qualifying for the accelerated benefit*

To be considered for an accelerated benefit, you will need to submit satisfactory evidence to Prudential that you have a life expectancy, due to illness or accident, of 6 months or less. The evidence must include certification from your physicians.

To qualify for the accelerated benefit:

- Life insurance coverage must be effective and all premiums paid in full.
- You must use the claim form provided by Prudential and follow the instructions on the claim form. Contact Prudential for a form.
- Your life insurance coverage must not have an irrevocable beneficiary or absolute assignment (see "Designating a beneficiary" on the next page for more information).

You are not eligible for this benefit if you elect the benefit involuntarily solely because:

- You are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise.
- You are required by a government agency to use this option in order to apply for, get or keep a government benefit or entitlement.

### *Payment of the accelerated benefit*

All accelerated benefits will be paid to you or your spouse/DP if you have been deemed terminally ill. The accelerated benefit will be paid in one lump sum. You may also elect to receive the benefit in 6 equal monthly installments. If you die before the lump sum (or all monthly installments) accelerated benefit is made, the benefit will be paid to the named beneficiary(ies).

**In no event will the amount of the accelerated benefit received, plus the amount your beneficiary receives at the time of your death, exceed the total coverage amount under the Life Insurance Plan.**

✓ Benefits received under the accelerated benefit are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. However, tax laws relating to accelerated benefit payments are complex, and you are advised to consult with a qualified tax advisor before requesting or receiving an accelerated benefit.

## Designating a beneficiary

You should designate a beneficiary or beneficiaries for your basic and optional life insurance coverage online via the APTIM Benefits Marketplace website at digital.alight.com/aptim or by calling 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT. You may change your beneficiary at any time.

✓ If you choose a trustee or a trust as your beneficiary, you will need to indicate the trustee's name, the name of the trust, and the date of the trust agreement.

If you do not designate a specific beneficiary, your benefit will be paid to the first beneficiary listed below who is living at the time of your death:

1. Your lawful spouse/DP; otherwise
2. Your naturally born or legally adopted children in equal shares; otherwise
3. Your surviving parents in equal shares; otherwise
4. Your siblings in equal shares; otherwise
5. Your estate.

Dependent coverage is paid to the employee. Any death benefit provided under a section of this coverage is payable to you. If you are not living at the death of a dependent*, the death benefit is payable to the dependent's estate or, at Prudential option, to any one or more of these surviving relatives of the dependent: wife; husband; mother; father; children; brothers; sisters.

In some cases, you may designate a beneficiary, called an irrevocable beneficiary, which you cannot change without his or her written consent. You may also transfer ownership of your coverage to someone else — this is called absolute assignment. To name an irrevocable beneficiary or execute an absolute assignment of your coverage, contact Prudential.

You are automatically the beneficiary of your children's optional life coverage.

* *If you and a dependent die in the same event and it cannot be determined who died first, the insurance will be payable as if that dependent died before you.*

## What does coverage cost?

Basic life insurance coverage is provided at no cost to you. However, the IRS requires taxes to be paid on the value of employer-paid life insurance greater than $50,000, which is known as "imputed income." If your basic life coverage is greater than $50,000, imputed income is added to your total annual compensation reported to the IRS, appears on your W-2 statement and is taxable at your regular income tax rate on a per-pay-period basis.

You pay the cost of optional life coverage through after-tax payroll deductions.

| For this optional life coverage: | Contributions are based on all of these: |
|---|---|
| **Employee** | ▪ The dollar amount of coverage you elect (based on your annual base pay).<br>▪ Your age as of January 1 of the current year. |
| **Spouse/DP** | ▪ The dollar amount of coverage you elect (to a maximum of your combined employee basic and optional life insurance amounts).<br>▪ Your spouse's/DP's age as of January 1 of the current year. |
| **Dependent child(ren)** | ▪ Whether dependent child(ren) coverage is elected. One premium insures all of your dependent children. |

Your monthly cost for optional life insurance coverage will be included in your enrollment materials. Optional life insurance premiums are based on your age, pay, and coverage level and are deducted each pay period. Your first premium payment will be deducted from your paycheck as soon as administratively possible after you are enrolled. If you make a change to your coverage during the plan year, your payroll contributions will change accordingly.

## How to file a claim

To make a claim for benefits under the Life Insurance Plan, you or your beneficiary should contact the APTIM Benefits Marketplace by calling 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT, or visit digital.alight.com/aptim. The APTIM Benefits Marketplace can assist you or your beneficiary on file with the claim filing process. Shortly after notification, your beneficiary on file will receive a condolence kit in the mail, or via email, that will contain instructions and the necessary paperwork that will need to be completed in order for the claim to be processed.

You can fax, mail, or email (scanned documents) all necessary documentation, along with a completed claim form and the beneficiary's information, including name, address, Social Security number, date of birth, and contact information. When all information is received, the claim is typically decided within five business days of receipt of all information necessary to process the claim.

**When to make a claim**

Claims for life insurance benefits should be reported as soon as possible — preferably within 31 days of the death. You should provide all necessary documentation within 90 days.

### If a claim is denied

You have specific rights if a claim is denied. See "Claims and appeals procedures" in the *Benefit Rights* section for details.

## Payment of benefits

When a claim for benefits is approved, Prudential will pay a benefit to the beneficiary(ies) equal to the coverage amount (less any accelerated benefit already paid), plus interest from the date of death until the date of payment, at a rate determined by the state in which the person died. The form of payment depends on the amount of the life insurance benefit.

- If the benefit is $5,000 or more, payment will be deposited into a free, interest-bearing checking account for use by the beneficiary at any time.
- If the benefit is less than $5,000, payment will be issued in a lump-sum check.

## Converting your coverage

If your life insurance coverage ends for any reason except your failure to pay premiums, you can convert it to an individual policy with Prudential. If you are no longer eligible for coverage under the plan due to your termination of employment, or another employment status change, Prudential will send you a conversion notice for your basic and optional life insurance coverage. To convert coverage, you must apply for the individual contract and pay the first premium by the later of:

- 31 days after you cease to be insured under the Life Insurance Plan; and
- 15 days after you have been given written notice of the conversion privilege. But, in no event may you convert the insurance to an individual contract if you do not apply for the contract and pay the first premium before 92 days after you cease to be insured under the Life Insurance Plan.

In addition:

- You will not be required to provide an EOI.
- Converted policies are subject to certain benefits and limits as outlined in the conversion brochure, which you will receive from Prudential.
- Your spouse/DP and dependent children may also be eligible to convert their coverage to individual policies. If your dependents' coverage ends but your employee coverage continues (for example, in the case of divorce, separation or a dependent's loss of eligibility), the dependent(s) can contact APTIM for information on how to convert their life insurance coverage.
- Your premium costs may change when your coverage is converted to an individual policy.

If you or a dependent dies within 31 days of losing coverage, the Life Insurance Plan will pay a benefit to your beneficiary(ies) even if you have not applied for an individual conversion policy.

✓ When your coverage under the Life Insurance Plan ends, Prudential will send you a conversion notice for your basic and optional life insurance coverage.

## Coverage while on Company-sponsored leaves

If, after the effective date of your basic or optional life coverage, you take a company-approved leave of absence, your basic and optional life insurance will remain in effect for the approved period of leave (provided you pay the optional life insurance premiums in a timely manner), but no more than twelve (12) months from the last day worked.

For more detailed information on leaves of absence and how your benefits are impacted by your particular leave, please contact APTIM Leaves.

## Coverage while disabled

If, after the effective date of your basic life coverage, you become totally disabled, as defined under the terms of the Long-Term Disability (LTD) Plan (see the *Long-Term Disability (LTD) Plan* section starting on page M-1), you will no longer be eligible for life insurance coverage, effective the day before your LTD benefit start date.

# Accidental Death & Dismemberment (AD&D) Plan



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

## Your AD&D coverage

Accidental Death and Dismemberment (AD&D) insurance pays a benefit in the event of accidental death, dismemberment, paralysis, or other covered losses. Your coverage consists of:

- Basic Company-paid AD&D; and
- Optional employee-paid AD&D.

Coverage is provided through Prudential.

### What is the difference between life and AD&D insurance?

Both life insurance and AD&D coverage help protect your family's financial security in the event of death. However, there are some basic differences between the plans.

- While both coverages pay a death benefit, the AD&D Plan pays only if the cause of death was accidental.
- The AD&D Plan also pays benefits when an accident results in the loss of a limb, paralysis, or other covered losses.

## How the AD&D Plan works

Upon gaining eligibility, you are automatically enrolled in basic AD&D coverage as long as you are actively at work on the day coverage is scheduled to begin. If you wish to elect optional AD&D, you must enroll in that coverage — available for you, your spouse/domestic partner (DP) and your dependent children — and pay the premiums through after-tax payroll deductions. For additional details on when your coverage is effective, see "When does coverage begin?" in the *General Information* section.

You can enroll in optional AD&D coverage during your new hire enrollment period or during annual benefits open enrollment online through the APTIM Benefits Marketplace.

✓ Even if you do not elect optional coverage, you should designate a beneficiary for your basic AD&D coverage. You can designate beneficiaries online via the APTIM Benefits Marketplace website at digital.alight.com/aptim or call 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT.

**Important note about effective date of coverage**

If you are not actively at work on the date your basic or optional life coverage would otherwise become effective, it will be effective the date you return to active service. This also applies to any future increases in your life insurance. If you are not actively at work on the day that an increase would take effect, it will take effect on the day you return to active service.

If your eligible spouse/DP or dependent child is hospital- or home-confined for medical care or treatment on the date his or her optional life coverage would otherwise be effective, coverage will be effective on the date he or she is no longer hospital- or home-confined.

## Basic Company-paid AD&D

The Company automatically provides basic AD&D coverage at no cost to you. Your basic coverage is equal to one times your current annual base pay, rounded to the next higher $1,000, if not already a multiple of $1,000. The maximum coverage amount is $750,000.

**Using annual base pay to calculate coverage amounts**

Annual base pay is your annual base salary, not including any bonuses, commissions, overtime pay or other extra compensation. For purposes of calculating your basic and optional AD&D coverage amounts, annual base pay is determined as of the November 1st of the plan year immediately prior to the date of a covered loss or your date of hire, whichever is later. Coverage increases due to changes in your annual base pay are effective each January 1st, not throughout the year. All coverage increases are subject to the requirement that you are actively at work on the day the increase takes effect.

## Optional employee-paid AD&D

You can elect optional AD&D coverage for yourself and your eligible dependents.

### *Optional employee AD&D*

You can elect optional AD&D coverage for yourself equal to one to five times your current annual base pay rounded to the next higher $1,000, if not already a multiple of $1,000. The maximum amount of coverage is $2,000,000.

✓ You can make changes to your optional AD&D coverage if you have a qualifying life event by visiting the APTIM Benefits Marketplace website at digital.alight.com/aptim or call 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT. The effective date of any coverage change is the date the change is processed via the APTIM Benefits Marketplace.

**Marie elects the maximum**

Marie's current annual base pay is $45,500. She elected optional employee only AD&D coverage of five times her annual base pay. Her coverage amount is calculated as follows:

$45,500 x 5 = $227,500,
rounded to the next higher $1,000 = $228,000

### *Optional family AD&D*

You may choose optional family AD&D coverage that covers you and your eligible dependents. If you elect family coverage, your coverage is up to five times your current annual base pay rounded to the next higher $1,000, if not already a multiple of $1,000 (to a maximum of $2,000,000) and your family members' coverage is:

| If you have the following dependents … | Your dependents' optional family AD&D coverage is … |
|---|---|
| **Spouse/DP only** | 60% of your optional employee coverage, to a maximum of $100,000. |
| **Child(ren) only** | 20% of your optional employee coverage, up to $25,000 per child. |
| **Spouse/DP and child(ren)** | 50% of employee coverage amount for your spouse/DP, to a maximum of $100,000, and 10% of employee coverage amount for your child(ren), up to $25,000 per child. |

### *Evidence of Insurability (EOI)*

If you or your spouse/DP are required to provide Evidence of Insurability (EOI), you will be able to complete the EOI process after you enroll.

Until a decision is made, you and/or your spouse/DP will be covered at the guaranteed coverage amount. If the EOI is approved, the optional employee life and/or spouse/DP life insurance coverage will become effective on the day the EOI decision is made, or according to plan rules, as long as you remain eligible and are actively at work.

If any medical exams or tests are required to complete the EOI process, Prudential will arrange for the needed services at no cost to you.

If you or your spouse/DP are required to provide an EOI, you will need to complete the Prudential EOI form available on digital.alight.com/aptim in the Document Library and mail to Prudential.

✓ It is your responsibility to contact the APTIM Benefits Marketplace to cancel coverage for your dependents when they are no longer eligible for coverage under the AD&D Plan.

**If both you and your spouse/DP work for the Company**

One person may not be covered as both an employee and a spouse/DP under the optional AD&D policy. If both you and your spouse/DP work for the Company and you both want optional AD&D coverage:

- You may elect optional AD&D coverage for yourself and your spouse/DP under family coverage (or your spouse/DP can elect optional AD&D coverage for you both under his or her family coverage); or
- You can each enroll in optional employee only AD&D coverage.

Your eligible dependent children can have AD&D coverage through either you or your spouse/DP, but not both of you.

**Frank enrolls his family**

Frank, an APTIM employee, elected optional family AD&D coverage of three times his current annual base pay of $58,200 for himself, his wife and his two children. Here is how he would calculate the optional AD&D coverage amount for each person:

- Frank: $175,000 ($58,200 x 3, rounded to the next higher $1,000).
- Frank's wife: $87,500 (which is 50% of Frank's coverage).
- Frank's children: $17,500 (which is 10% of Frank's coverage).

## What the AD&D Plan pays

The AD&D Plan pays a benefit amount to the insured person or his or her beneficiary in the event of death or bodily injuries occurring within 365 days of a covered accident, as indicated in the chart below. No benefit will be payable for a loss which is not shown in this chart.

| Loss of or by reason of: | Then the AD&D Plan pays this portion of your benefit: |
|---|---|
| **Life** | 100% |
| **Sight of both eyes** | 100% |
| **Speech and hearing in both ears** | 100% |
| **Both hands** | 100% |
| **Both feet** | 100% |
| **One hand and one foot** | 100% |
| **One hand and sight of one eye** | 100% |
| **One foot and sight of one eye** | 100% |
| **Quadriplegia** | 100% |
| **Triplegia** | 75% |
| **One arm** | 75% |
| **One leg** | 75% |
| **Paraplegia** | 75% |
| **Sight of one eye** | 50% |
| **Speech** | 50% |
| **Hearing in both ears** | 50% |
| **One hand** | 50% |
| **One foot** | 50% |
| **Hemiplegia** | 50% |
| **Uniplegia** | 25% |
| **Thumb and index finger of the same hand (permanent loss)** | 25% |
| **Four fingers of the same hand (permanent loss)** | 25% |
| **All toes on one foot (permanent loss)** | 25% |
| **Big toe (permanent loss)** | 13% |
| **Coma** | 1% per month, up to 11 months with balance payable in 12th month of continuous coma |

**If the same accident causes more than one of these losses, no more than your amount of insurance under this coverage at the time of the accident will be paid for all losses resulting from injuries sustained in that accident.**

Covered losses are defined as follows:

| This covered loss: | Is defined as: |
|---|---|
| **Loss of hand or foot** | Complete severance through or above the wrist or ankle joint. Severance means complete separation and dismemberment of the limb from the body. |
| **Loss of sight** | Total and permanent loss of sight of the eye. Corrected visual acuity must be 20/200 or worse or the field of vision must be less than 20 degrees. The loss of sight must be irrecoverable by natural, surgical, or artificial means. |
| **Loss of speech** | Total and permanent loss of audible communication that continues for at least 12 consecutive months following the covered accident. The loss of speech must be irrecoverable by natural, surgical, or artificial means. |
| **Loss of hearing** | Total and permanent loss of hearing in both ears, which cannot be corrected by any hearing aid or device. The loss of hearing must be irrecoverable by natural, surgical, or artificial means. |
| **Loss of thumb and index finger or four fingers on the same hand** | Permanent loss of thumb and index finger of the same hand or permanent loss of four fingers on the same hand by severance at or above the point at which they are attached to the hand. |
| **Uniplegia** | Total paralysis of one upper or one lower limb. |
| **Loss of all toes on the same foot** | Permanent loss of all toes on the same foot or the big toe by severance at or above the point at which they are attached to the foot. |
| **Coma** | A profound state of unconsciousness which results directly and independently from all other causes from a covered accident, and from which the person is not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a covered injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of a covered accident. |
| **Quadriplegia** | The total and permanent paralysis of both upper and both lower limbs. Paraplegia means the total and permanent paralysis of both lower limbs. Hemiplegia means the total and permanent paralysis of the upper and lower limbs on one side of the body. |
| **Triplegia** | The total and permanent paralysis of three limbs. |

## Other plan features

### Seat belt and air bag benefit

**Additional benefit for loss of life as a result of an accident in an automobile while using a seat belt:** This additional benefit for your loss of life only applies if you sustain an accidental bodily injury resulting in the loss while:

- You are a driver or passenger in an automobile;
- You are wearing a seat belt in the manner prescribed by the vehicle's manufacturer; and
- The actual use of a seat belt at the time of the injury is verified in an official report of the accident, or is certified in writing by the investigating official(s).

*Losses not covered under this additional benefit:* A loss is not covered under this additional benefit if it results from driving or riding in any automobile used in a race or a speed or endurance test, or for acrobatic or stunt driving, or for any illegal purpose.

*Additional amount payable under this additional benefit:* An amount equal to the lesser of: (1) 10% of your amount of insurance; and (2) $25,000.

If it cannot be determined that you were wearing a seat belt at the time of the accident, a benefit of $1,000 will be paid.

**Additional benefit for loss of life as a result of an accident in an automobile while using an air bag:** This additional benefit for your loss of life only applies if this test is met —

You sustain an accidental bodily injury resulting in the loss while:

(a) you are a driver or passenger in an automobile;

(b) you are wearing a seat belt in the manner prescribed by the vehicle's manufacturer;

(c) the actual use of a seat belt at the time of the injury is verified in an official report of the accident, or is certified in writing by the investigating official(s);

(d) the automobile is equipped with a factory-installed air bag; and

(e) a properly functioning air bag was deployed for the seat that you occupied.

*Losses not covered under this additional benefit:* A loss is not covered under this additional benefit if it results from driving or riding in any automobile used in a race or a speed or endurance test, or for acrobatic or stunt driving, or for any illegal purpose.

*Additional amount payable under this additional benefit:* An amount equal to the lesser of: (1) 5% of your amount of insurance; and (2) $10,000.

### Childcare benefit

If you die in a covered accident and you have surviving dependent children under age 13, a childcare benefit equal to 5% of your AD&D benefit (to a maximum of $5,000 per year) is payable for each surviving dependent child for up to four consecutive years, but not beyond the date the child reaches age 13. This benefit is payable if the death results directly and independently of all other causes from a covered accident and these conditions are met:

- You have AD&D coverage for your dependent child(ren) in effect on the date of the accident; and
- You have one or more surviving dependent children under age 13 and they are enrolled in a childcare center on the date of the accident or they enroll in a childcare center within 90 days from the date of the accident.

The childcare benefit is payable for each dependent child less than age 13 who:

- Is your child who wholly depends on you for support and maintenance on the date of death; and
- Is enrolled at a childcare center on the date of death; or
- Becomes enrolled at a childcare center within 90 days after the date of death.

## Tuition reimbursement benefit

This benefit only applies once. The plan provides a tuition reimbursement benefit for a dependent child upon the employee's or covered spouse's/DP's death in a covered accident. This benefit is payable for each dependent child who is less than age 26 who: wholly depends on the employee for support and maintenance on the date of death, and is enrolled as a full-time student in a school on the date of death; or is at the 12th grade level and becomes a full-time student in a school within 365 days after that date.

The benefit is an amount equal to the least of (a) the actual annual tuition (exclusive of room and board, books and fees) charged by the school, (b) 5% of the amount of insurance on the person, and (c) $5,000, payable annually for up to four consecutive years, but not beyond the date the child reaches age 26.

If there is no dependent child eligible for this benefit, a benefit of $1,000 will be paid.

## Spouse/domestic partner (DP) tuition reimbursement benefit

If the employee dies in a covered accident, the plan provides a tuition reimbursement benefit for a professional or trade program for the purpose of obtaining an independent source of support or enriching that spouse's/DP's ability to earn a living.

The benefit is an amount equal to the least of (a) the actual tuition charged for the program, (b) 5% of your amount of insurance, and (c) $5,000. Enrollment in that program must occur within 12 months of the employee's death. This benefit is payable for only one year.

## Exposure and disappearance coverage

Exposure to the elements will be considered an accidental bodily injury. Exposure to the elements means exposure to severe hot or cold weather that results in actual significant physical injury including sun stroke, heat stroke, and frostbite. It will be presumed that you have suffered a loss of life if your body has not been found within one year of disappearance, stranding, sinking, or wrecking of any vehicle in which you were an occupant.

## What is not covered

AD&D Plan benefits are not payable for a loss that results, directly or indirectly, from any of the following circumstances. Exclusions include, but are not limited to:

| Not covered | Details |
|---|---|
| **Crime** | Commission of, or attempt to commit, an assault or a felony. |
| **Military** | ▪ Injury or death while the insured is serving full-time active duty for more than 31 days in any armed forces. However, this does not include Reserve or National Guard active duty for training.<br>▪ If the insured sends proof of military service, Prudential will refund pro rata the premium paid to cover the insured during a period of such service. |
| **War or riot** | ▪ Injury or death sustained during a declared or undeclared war or act of war and includes resistance to armed aggression. Terrorism is not considered an act of war. Terrorism means the deliberate use of violence or the threat of violence against civilians to create an emotional response through the suffering of victims or to achieve military, political, religious, or social objectives.<br>▪ Injury or death sustained during commission of, or active participation in, a riot or insurrection. |
| **Sickness** | ▪ Sickness, disease or bodily infirmity, whether the loss results directly or indirectly from the sickness.<br>▪ Medical or surgical treatment of sickness, whether the loss results directly or indirectly from the treatment.<br>▪ Bacterial or viral infection, no matter how contracted.<br>This does not include:<br>(a) a pyogenic infection resulting from an accidental cut or wound; or<br>(b) a bacterial infection resulting from accidental ingestion of a contaminated substance. |
| **Suicide or self-injury** | ▪ Suicide.<br>▪ Attempted suicide while sane or insane.<br>▪ Whenever an insured intentionally injures himself or herself. |
| **Travel or flight** | Travel or flight in any vehicle used for aerial navigation, if any of these apply:<br>▪ You are riding as a passenger in any aircraft not intended or licensed for the transportation of passengers.<br>▪ You are performing as a pilot or a crew member of any aircraft.<br>▪ You are riding as a passenger in an aircraft owned, operated, controlled or leased by or on behalf of the contract holder or any of its subsidiaries or affiliates.<br>This includes getting in, out, on or off any such vehicle.<br>▪ If the insured is:<br>– A student taking a flying lesson.<br>– Hang-gliding.<br>– Bungee jumping.<br>– Skydiving.<br>– Parachuting, except where the insured has to make a parachute jump for self-preservation.<br>– Serving as a pilot or crew member and is not riding as a passenger. |
| **Driving under the influence** | Being under the influence of alcohol or alcohol intoxication, including but not limited to having a blood alcohol level above the limit for permissible operation of a motor vehicle in the jurisdiction where the loss occurred, regardless of whether the person: (a) was operating a motor vehicle; and (b) was convicted of an alcohol-related offense.<br>Being under the influence of or taking any non-prescription drug, medication, narcotic, stimulant, hallucinogen, barbiturate, amphetamine, gas, fumes or inhalants, poison, or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by and administered in accordance with the advice of the insured's doctor. |

## Designating a beneficiary

You should designate a beneficiary or beneficiaries — to be paid in the event of your death — for your basic and optional AD&D coverage online via the APTIM Benefits Marketplace website at digital.alight.com/aptim or call 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT. You may change your beneficiary at any time.

✓ If you choose a trustee or a trust as your beneficiary, you will need to indicate the trustee's name, the name of the trust, and the date of the trust agreement.

If you do not designate a specific beneficiary for your AD&D coverage, your benefit will automatically be paid to the first beneficiary listed below who is living at the time of your death:

1. Your lawful spouse/DP; otherwise
2. Your natural born or legally adopted child(ren) in equal shares; otherwise
3. Your surviving parents in equal shares; otherwise
4. Your siblings in equal shares; otherwise
5. Your estate.

In some cases, you may designate a beneficiary, called an irrevocable beneficiary, which you cannot change without his or her written consent. You may also transfer ownership of your coverage to someone else — this is called absolute assignment. To name an irrevocable beneficiary or execute an absolute assignment of your coverage, contact Prudential.

You are the beneficiary of your family members' optional AD&D death benefit.

## What does coverage cost?

Basic AD&D insurance coverage is provided at no cost to you. You pay the cost of optional AD&D coverage through after-tax payroll deductions. Your cost is determined based on the amount of optional coverage you elect and whether you choose employee only or family coverage.

Your cost for coverage will be included in your enrollment materials. Optional AD&D premiums are deducted each pay period. Your first premium payment will be deducted from your paycheck as soon as administratively possible after you are enrolled. If you make a change to your coverage during the plan year, your payroll contributions will change accordingly.

## How to file a claim

To make a claim for benefits under the AD&D Plan, you or your beneficiary should visit the APTIM Benefits Marketplace website at digital.alight.com/aptim or call 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT.

**When to make a claim**

Claims for AD&D benefits should be reported as soon as possible — preferably within 31 days of the death or accident. You should provide all necessary documentation within 90 days.

### If a claim is denied

You have specific rights if a claim is denied. See "Claims and appeals procedures" in the *Benefit Rights* section for details.

## Payment of benefits

When a claim for benefits is approved under the AD&D Plan, Prudential will pay a benefit to the claimant or beneficiary(ies) equal to the coverage amount plus interest from the date of death or accident (if applicable) until the date of payment, at a rate determined by the state in which the accident occurred. The form of payment depends on the amount of the AD&D benefit.

- If the benefit is $5,000 or more, payment will be deposited into a free, interest-bearing checking account for use by the beneficiary at any time.
- If the benefit is less than $5,000, payment will be issued in a lump-sum check.

# Travel Accident Plan



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

## Your travel accident insurance coverage

Travel accident insurance pays a benefit if you die or are dismembered as the result of an accident while traveling on "Company business." Company business includes all circumstances arising from or occurring while you are traveling on assignment by or at the direction of the Company, including relocation trips (which is an assignment to a new regular place of employment).

This coverage is provided at no cost to you, and is paid in addition to any basic or optional life insurance or AD&D insurance you have. Coverage is provided through AIG.

## How the Travel Accident Plan works

You are automatically enrolled in Company-paid travel accident coverage. For details on when your coverage is effective, see "When does coverage begin?" in the *General Information* section.

For any authorized Company business, coverage starts when you leave your place of regular employment or residence, whichever is later, and ends when you return to your place of regular employment or residence, whichever is earlier. It includes a personal deviation of seven days or less. Coverage includes any accident while in travel status on Company business, including pedestrian or hotel accidents or accidents while visiting construction sites.

You are covered anywhere in the world and coverage includes most modes of travel, except as indicated under "What is not covered" on page K-4.

✓ **Your spouse/domestic partner (DP) and dependent child(ren) are also covered while traveling with you on business, relocation trips, home leave or vacation trips paid for by the Company.** See "Spouse/domestic partner (DP) and child(ren) coverage" on page K-3 for their coverage amounts.

### Your coverage amount

Your travel accident coverage is equal to five times your current annual base pay, rounded to the next higher $1,000, if not already a multiple of $1,000. The maximum coverage amount is $750,000.

Annual base pay is your annual base salary, not including any bonuses, commissions, overtime pay, or other compensation.

**Christopher's coverage**

Christopher's current annual base pay is $155,000. His travel accident coverage is five times his annual base pay. Since that amount is over the benefit maximum, his coverage is the maximum $750,000.

## What the Travel Accident Plan pays

If you die as the result of a covered accident, the Travel Accident Plan pays a benefit equal to 100% of your coverage amount to **your beneficiary**.

Your travel accident coverage pays a benefit to **you** for your dismemberment resulting from a covered accident (or in the case of your spouse/DP or dependent child's death or dismemberment as the result of a covered accident).

### What is dismemberment?

Dismemberment includes:

- Loss of hands or feet, which means complete severance through or above the wrist or ankle joint. Severance means complete separation and dismemberment of the limb from the body.
- Loss of sight, which means the total and permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.
- Loss of speech, which is the total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means.
- Loss of hearing, which is the total and permanent loss of hearing in both ears. The loss of hearing must be irrecoverable and cannot be corrected by any means.
- Quadriplegia, which is the total loss of use of both upper and lower limbs.
- Hemiplegia, which is the total loss of use of the upper and lower limbs on one side of the body.
- Paraplegia, which is the total loss of use of both lower limbs or both upper limbs.
- Uniplegia, which is the total loss of use of one lower limb or one upper limb.
- Loss of a thumb and index finger of the same hand, which means complete severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

| Based on your dismemberment: | The Travel Accident Plan pays this portion of your benefit: |
|---|---|
| **Loss of both hands or both feet** | 100% |
| **Loss of sight of both eyes** | 100% |
| **Any combination of two of the following: loss of one hand, loss of one foot, loss of sight in one eye, loss of speech or loss of hearing** | 100% |
| **Quadriplegia** | 100% |
| **Hemiplegia** | 75% |
| **Paraplegia** | 75% |
| **Loss of one hand, loss of one foot, loss of sight in one eye, loss of speech or loss of hearing** | 50% |
| **Uniplegia** | 25% |
| **Loss of a thumb and index finger of the same hand** | 25% |

**Annette's accident**

Annette was in a car accident while traveling on Company business. Unfortunately, as a result of the accident, she has total and permanent loss of sight in one eye. Her annual base pay is $40,000 so her travel accident coverage is equal to $200,000. Since her loss of sight qualifies as dismemberment and she was traveling on Company business at the time of the accident, the coverage will pay her an amount equal to 50% of her travel accident benefit, or $100,000.

## Spouse/domestic partner (DP) and child(ren) coverage

If your spouse/DP and/or dependent child(ren) are traveling with you on business, relocation trips, home leave, or vacation trips paid for by the Company, and they die or become dismembered as a result of a covered accident during the travel, their coverage is:

- $100,000 for your covered spouse/DP.
- $50,000 for your covered child(ren).

Coverage for your spouse/DP and child(ren), including the portion of the benefit paid in the case of dismemberment, is subject to the same conditions as employee coverage.

## Aggregate benefit maximum

If multiple employees are involved in the same accident, the insurer will pay a maximum of $10,000,000 in aggregate for all covered persons.

## Additional benefits

### *Coma benefit*

If you or your spouse/DP or dependent child(ren) become comatose within 31 days of a covered accident and remain in a coma for at least 31 days, your travel accident coverage will pay a benefit equal to 1% of the coverage amount per month for up to 11 months. You or your spouse/DP or dependent child(ren) are deemed in a "coma" if you are in a stupor or a state of complete and total unconsciousness. Payments under the coma benefit end on the earliest of the following:

- The end of the month in which the person recovers from the coma;
- The end of the month in which the person dies; or
- The end of the 11th month for which coma benefits have been paid.

After the end of the 11th month in which coma benefits have been paid, if you or your spouse/DP or dependent child(ren) remain in a coma, the plan will pay a lump sum equal to 100% of the coverage amount.

### *Rehabilitation benefit*

If you or your spouse/DP or dependent child(ren) are participating in a rehabilitation program, as prescribed by a doctor, due to a spinal cord, nervous system, or closed head injury resulting directly from a covered accident, you are eligible for a benefit equal to 10% of the coverage amount, to a maximum benefit of $25,000. Benefits are payable for the facility providing the rehabilitation program and for immediate family members' travel expenses to and from the rehabilitation facility (immediate family members include parents, grandparents, spouses/DPs, children, brothers, sisters, and in-laws). Payments under the rehabilitation benefit end on the earliest of the following:

- The date the person completes the rehabilitation program;
- The date the person is no longer totally disabled as defined by the plan; or
- The date the person dies.

### *Seatbelt and airbag benefit*

If you or your spouse/DP or dependent child(ren) die or are dismembered from injuries sustained in a covered automobile accident while wearing a seatbelt, your travel accident coverage will pay an additional benefit equal to 10% of the coverage amount, to a maximum of $25,000. If you or your spouse/DP or dependent child(ren) die or are dismembered from injuries sustained in a covered automobile accident and you were positioned in a seat protected by a properly functioning and deployed airbag, you will receive an additional benefit equal to 10% of the coverage amount, to a maximum of $10,000.

Verification of the proper use of a seatbelt and/or properly deployed airbag must be part of the official police report or the use must be certified, in writing, by the investigating officer and submitted with the claim for benefits. If this is not available or if the report is unclear, a default benefit amount of $2,500 will be paid.

### *Special counseling benefit*

If you or your spouse/DP or dependent child(ren) are dismembered as the result of a covered accident and the injured person obtains mental health counseling, your travel accident coverage will pay a benefit of $150 per counseling session, to a maximum of 10 sessions and $1,500 per covered accident.

## What is not covered

Plan benefits are not payable for a loss that results, directly or indirectly, from any of the following circumstances. Exclusions include, but are not limited to:

| Not covered | Details |
|---|---|
| **Crime** | Commission of, or attempt to commit, a felony. |
| **Military** | Injury while you are serving full-time active duty in any armed forces. |
| **Personal travel** | ▪ Commuting to or from work.<br>▪ Personal vacation trips, except a personal deviation of seven days or less while on a Company business trip. |
| **Sickness** | Any sickness, disease, bacterial or viral infection that is not caused by an accidental cut, wound or food poisoning. |
| **Suicide or self-injury** | ▪ Suicide.<br>▪ Attempted suicide.<br>▪ Whenever an insured intentionally injures himself or herself. |
| **War risk** | No war risk coverage will be extended to travel to the following listed countries unless the trip is first reported to the Company prior to the departure date of the insured person and an additional charge has been approved and invoiced: Afghanistan, Russia-North Caucasus, Iraq, Libya, Somalia, Yemen and Ukraine. |
| **Riot** | Commission of or active participation in a riot or insurrection. |
| **Workers' Compensation** | Injury covered by workers' compensation, employers' liability laws, or similar occupational benefits. |

### General exclusions

No coverage shall be provided under this policy and no payment shall be made for any loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the loss is an accidental bodily injury:

1. Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury.
2. Travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, whether as a passenger, pilot, operator or crew member, unless specifically provided by this policy.
3. Declared or undeclared war, or any act of declared or undeclared war unless specifically provided by this policy.

## Designating a beneficiary

In the event of your death, your beneficiary for your travel accident coverage is the same as the beneficiary you designate for your life insurance coverage (see the *Life Insurance Plan* section beginning on page I-1). You may change your beneficiary at any time.

If you do not designate a beneficiary, your travel accident death benefit will automatically be paid to the first beneficiary listed below who is living at the time of your death:

1. Your lawful spouse/DP; otherwise
2. Your natural born or legally adopted child(ren) in equal shares; otherwise
3. Your surviving parents in equal shares; otherwise
4. Your siblings in equal shares; otherwise
5. Your estate.

You are the beneficiary of your spouse/DP and children's travel accident benefits.

## What does coverage cost?

Travel accident insurance coverage is provided at no cost to you.

## How to file a claim

To make a claim for benefits under the Travel Accident Plan, you or your beneficiary should contact AIG at 1-877-244-6871 (within the U.S.) or 1-715-346-0859 (outside of the U.S.), or visit www.aig.com/us/travelguardassistance to log into the app. Claims for benefits must be filed within 90 days after a covered loss. You will need the following information to report a claim:

- Name of the policy holder.
- Policy number.
- Name of the claimant.
- Type of claim (death or dismemberment).
- Mailing address to send the claim form.

After you report a claim, AIG will send you or your beneficiary a claim form. Mail the completed form, along with all other required information, to AIG at the address on the form.

### If a claim is denied

You have specific rights if a claim is denied. See "Claims and appeals procedures" in the *Benefit Rights* section for details.

## Payment of benefits

All benefits, except for your loss of life, will be paid to you. Benefits for your death will be paid to your beneficiary (see "Designating a beneficiary" on this page).

## Converting your coverage

You cannot convert your travel accident insurance coverage to an individual policy.

# Short-Term Disability and Salary Continuation Plan/ Short-Term Disability (STD)



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

## Which plan do I have?

APTIM offers coverage that replaces all or part of your pay if you miss work because of a medical condition. Your employee group determines your plan.

- If you are an hourly/craft employee, "Hourly/Craft Short-Term Disability (STD) Plan," starting on this page, includes details on your benefits.
- If you are a Redstone Union employee, see "Redstone Union Short-Term Disability (STD) Plan," starting on page L-5.
- If you are a salaried employee, see "Salary Continuation Plan/Short-Term Disability (STD)," starting on page L-9.

## Hourly/Craft Short-Term Disability (STD) Plan

If you are an hourly/craft employee, you may elect Short-Term Disability (STD) benefits that replace a portion of your wages when you are unable to work because of an injury or sickness.

STD coverage is provided through Prudential, which we will refer to as the "Insurance Company" in this summary. As the Plan Administrator, the Insurance Company determines when someone qualifies for STD benefits.

Here are the plan basics:

| | |
|---|---|
| **Do I need to enroll?** | Yes. You need to enroll in STD coverage when you first become benefit eligible after your date of hire or during annual benefits open enrollment. |
| **Are my dependents eligible?** | No. STD benefits are for employees only. |
| **Who pays?** | You pay the cost of STD coverage. |
| **What is my benefit?** | 60% of your base pay (up to $3,000 per week) for up to 26 weeks. |
| **What if I get other disability benefits?** | Your STD benefits will be reduced by the amount you receive from other qualifying disability sources. See page L-3 for details. |

### Eligibility and enrollment

The *General Information* section contains most of the eligibility and enrollment information for the Company benefits. However, there are a few specific rules about STD coverage.

#### *Am I eligible?*

Eligible employees include full-time and part-time hourly/craft employees with a normally scheduled workweek of at least 20 hours. You are ***not*** eligible if you are:

- Covered by a collective bargaining agreement.
- Working outside the U.S. and do not have any U.S. source employment income.
- A temporary/contracted hire.

#### *When and how does my coverage begin?*

If you are eligible, you can enroll in STD coverage when you first become benefit eligible after your date of hire or during annual benefits open enrollment. Your coverage begins the first of the month following 30 days from your date of hire (as a new hire) or January 1 of the following year (if you enroll during annual benefits open enrollment). If you are not actively at work on the date your coverage is scheduled to begin, your coverage will take effect upon your return to active service.

If you elect coverage for the first time after your initial eligibility period, you may be required to provide an EOI.

### What does coverage cost?

You pay the full cost of STD coverage through payroll deductions. Your first premium payment will be deducted from your paycheck as soon as administratively possible after coverage begins or, if during annual benefits open enrollment, the first pay period of the following calendar year.

Your contributions for coverage will be deducted from your paycheck on an after-tax basis.

## How does the plan work?

The plan provides a benefit if you are disabled because of sickness or injury and are not able to work.

| | |
|---|---|
| **When do payments begin?** | Accident — First day of disability. |
| | Sickness — Eighth day of disability. |
| **What is the benefit amount?** | 60% of your base pay, up to $3,000 per week. Your base pay is equal to your weekly base pay, not including any bonuses, commissions, overtime pay, or other compensation. |
| **What is the benefit duration?** | Up to 26 weeks. |

### *What is a disability?*

Under the STD Plan, disability means that, as a result of injury or sickness:

- You cannot perform one or more of the essential duties of your job; and
- You are unable to earn 80% or more of your earnings from working in your regular occupation.

To be considered disabled and eligible for STD benefits:

- Your condition must require the regular care of a doctor.
- You must be able to provide proof of your continuing disability at reasonable intervals. If you cannot provide that proof, or if you refuse to be examined by a physician (designated and paid for by the Insurance Company), you will no longer be considered disabled.
- You are required to apply for all other income benefits for which you may be eligible, and provide a statement of those amounts if requested by the Insurance Company. If you do not apply for all other income benefits, the Insurance Company has the right to reduce your benefit by the estimated amount of any other income benefits for which you may be eligible.

### *Other income benefits*

Your STD benefit may be offset by certain other disability income benefits. If you are eligible for these other benefits, your STD benefit is reduced so that your total weekly benefit from all sources does not exceed the maximum APTIM benefit amount.

Here are just a few examples of other income benefits and how they affect your STD benefit:

| Benefits that may offset STD benefits | Benefits that *do not* offset STD benefits |
|---|---|
| ▪ Social Security benefits.<br>▪ Other state-mandated benefits. | ▪ Individual disability policies.<br>▪ "No fault" auto insurance.<br>▪ 401(k) account distributions.<br>▪ Employee savings plans. |

Any increases to the offset amounts as the result of cost of living or statutory changes will not further reduce your STD benefit.

**Sandra's disability income**

Sandra was hit hard by the flu and even had to be hospitalized in the beginning. It took nine weeks before she could return to work. Because she lived in a state that provided disability benefits, she applied for and received $50 each week from the state. To adjust for the state disability benefits, the maximum Company STD benefit of 60% of her pay ($160) she would have received was reduced to $110, providing her with total disability benefits of $160 per week.

### *When do STD payments end?*

You will continue to be eligible for STD Plan benefit payments for as long as you remain disabled, as determined by the Insurance Company, until one of the following occurs:

- You are no longer disabled or you are deceased.
- You fail to provide proof of your disability in the required time period.
- You are no longer under the regular care of a physician or refuse the Insurance Company's request to be examined by a physician.
- You reach the end of the 26-week maximum benefit period.

**Cliff's accident**

A year after joining APTIM as an hourly/craft employee, Cliff was in a car accident and suffered serious injuries. After a hospital stay of three weeks, he was in a rehabilitation center for another two months before returning to work. Luckily, Cliff had elected STD coverage so, during his 11 weeks of disability, Cliff collected a weekly benefit of $160 for a total of $1,760 in STD benefits.

## Returning to work

When you are ready to return to work, contact your supervisor and APTIM Leaves. You may be required to provide a medical release from your doctor.

### *Vocational rehabilitation*

Depending on the restrictions of your disability, the Company may offer vocational rehabilitation to help you return to work in your current job or a different position. Vocational rehabilitation means employment or services that prepare you, if disabled, to resume gainful work.

Vocational rehabilitative services include, when appropriate, any necessary and feasible vocational testing, vocational training, work-place modification, prosthesis or job placement.

**Cliff is back at work**

Cliff was off work for 11 weeks, during which he recovered from severe injuries to his shoulder and legs from a car accident. His job required a lot of physical work, and Cliff was not yet ready to handle that. The Company offered him training for a job that he could do on a computer while sitting at a desk. As a result, Cliff was able to return to work much sooner than anticipated.

### *Rehabilitative employment*

You may participate in an approved program of rehabilitative employment while receiving STD benefits. The sum of your weekly benefit and total income received under the rehabilitative employment provision may not exceed 100% of your pre-disability weekly earnings. If this sum exceeds your pre-disability weekly earnings, the weekly benefit paid by the Company will be reduced proportionately. Your maximum period of rehabilitation payment is 6 months.

### *What if I become disabled after returning to work?*

STD benefits are payable on a per-occurrence basis. If you return to work as an active full-time or part-time employee working at least 20 hours a week or more and you become disabled again, it is considered a new occurrence and after meeting your elimination period, you will receive your full STD benefit for the new disability.

However, it will be treated as the same period of disability — and your 26-week maximum will not start again (and you will not need to meet a new elimination period) — if:

- Your disability is due to the same or a related cause; and
- You have been back at work as an active full-time or part-time employee working at least 20 hours a week for 30 consecutive days or less.

## When benefits are not paid

| Exclusions | |
|---|---|
| **STD benefits are not paid for disabilities resulting from …** | ▪ Commission of a crime for which you have been convicted under state or federal law.<br>▪ Cosmetic surgery that is not medically necessary.<br>▪ Injury as a result of working for pay or profit for another employer.<br>▪ Injury, sickness, mental illness or nervous disorder, substance abuse, or pregnancy that is not being treated by a physician.<br>▪ Intentional self-inflicted injury or attempted suicide.<br>▪ Occupational-related sickness or injury.<br>▪ Participation in a riot.<br>▪ War or act of war (declared or not). |
| **In addition, benefits will not be paid if …** | ▪ You are incarcerated.<br>▪ You lose your license that is a requirement of your job, unless it is due to a covered disability.<br>▪ You are eligible for benefits for a disability under a prior disability plan that:<br>– Was sponsored by the employer; and<br>– Was terminated before the effective date of this plan. |

## How to request benefits

If you become sick or injured and you think you are eligible for STD benefits, you must:

- Call Prudential, the Plan Administrator, at 1-800-842-1718;
- Contact APTIM Leaves; and
- Notify your supervisor or manager.

## Does collecting STD benefits affect my other APTIM benefits?

No. You will continue to be eligible for your other Company benefits, including medical and life insurance, while you are receiving STD benefits.

You will be billed for your portion of benefit premiums by Alight. All payments must be paid directly to Alight in order to continue Company benefits.

# Redstone Union Short-Term Disability (STD) Plan

If you are a Redstone Union employee, you may elect Short-Term Disability (STD) benefits that replace a portion of your wages when you are unable to work because of an injury or sickness.

STD coverage is provided through Prudential, which we will refer to as the "Insurance Company" in this summary. As the Plan Administrator, the Insurance Company determines when someone qualifies for STD benefits.

Here are the plan basics:

| | |
|---|---|
| **Do I need to enroll?** | Yes. You need to enroll in STD coverage when you first become benefit eligible after your date of hire or during annual benefits open enrollment. |
| **Are my dependents eligible?** | No. STD benefits are for employees only. |
| **Who pays?** | You pay the cost of STD coverage. |
| **What is my benefit?** | 66.67% of your base pay (up to $750 per week) for up to 13 weeks. |
| **What if I get other disability benefits?** | Your STD benefits will be reduced by the amount you receive from other qualifying disability sources. See page L-3 for details. |

## Eligibility and enrollment

The *General Information* section contains most of the eligibility and enrollment information for the Company benefits. However, there are a few specific rules about STD coverage.

### *Am I eligible?*

Eligible employees include active full-time and part-time Redstone Union employees working a minimum of 20 hours per week working in the United States or U.S. Territories. You are ***not*** eligible if you are:

- Working outside the U.S. and do not have any U.S. source of income.
- A temporary/contracted hire.

### *When and how does my coverage begin?*

If you are eligible, you can enroll in STD coverage when you first become benefit eligible after your date of hire or during annual benefits open enrollment. Your coverage begins the first of the month following 30 days from your date of hire (as a new hire) or January 1 of the following year (if you enroll during annual benefits open enrollment). If you are not actively at work on the date your coverage is scheduled to begin, your coverage will take effect upon your return to active service.

If you elect coverage for the first time after your initial eligibility period, you may be required to provide an EOI.

## What does coverage cost?

You pay the full cost of STD coverage through payroll deductions. Your first premium payment will be deducted from your paycheck as soon as administratively possible after coverage begins or, if during annual benefits open enrollment, the first pay period of the following calendar year.

Your contributions for coverage will be deducted from your paycheck on an after-tax basis.

## How does the plan work?

The plan provides a benefit if you are disabled because of sickness or injury and are not able to work.

| | |
|---|---|
| **When do payments begin?** | Accident — Eighth day of disability. |
| | Sickness — Eighth day of disability. |
| **What is the benefit amount?** | 66.67% of your base pay, up to $750 per week. Your base pay is equal to your weekly base pay, not including any bonuses, commissions, overtime pay, or other compensation. |
| **What is the benefit duration?** | Up to 13 weeks. |

### *What is a disability?*

Under the STD Plan, disability means that, as a result of injury or sickness:

- You cannot perform one or more of the essential duties of your job; and
- You are unable to earn 80% or more of your earnings from working in your regular occupation.

To be considered disabled and eligible for STD benefits:

- Your condition must require the regular care of a doctor.
- You must be able to provide proof of your continuing disability at reasonable intervals. If you cannot provide that proof, or if you refuse to be examined by a physician (designated and paid for by the Insurance Company), you will no longer be considered disabled.
- You are required to apply for all other income benefits for which you may be eligible, and provide a statement of those amounts if requested by the Insurance Company. If you do not apply for all other income benefits, the Insurance Company has the right to reduce your benefit by the estimated amount of any other income benefits for which you may be eligible.

### *Other income benefits*

Your STD benefit may be offset by certain other disability income benefits. If you are eligible for these other benefits, your STD benefit is reduced so that your total weekly benefit from all sources does not exceed the maximum APTIM benefit amount.

Here are just a few examples of other income benefits and how they affect your STD benefit:

| Benefits that may offset STD benefits | Benefits that *do not* offset STD benefits |
|---|---|
| ▪ Social Security benefits.<br>▪ Other state-mandated benefits. | ▪ Individual disability policies.<br>▪ "No fault" auto insurance.<br>▪ 401(k) account distributions.<br>▪ Employee savings plans. |

Any increases to the offset amounts as the result of cost of living or statutory changes will not further reduce your STD benefit.

**Kristy's disability income**

Kristy was hit hard by the flu and even had to be hospitalized in the beginning. It took nine weeks before she could return to work. Because she lived in a state that provided disability benefits, she applied for and received $50 each week from the state. To adjust for the state disability benefits, the maximum Company STD benefit of 66.67% of her pay ($160) she would have received was reduced to $110, providing her with total disability benefits of $160 per week.

### *When do STD payments end?*

You will continue to be eligible for STD Plan benefit payments for as long as you remain disabled, as determined by the Insurance Company, until one of the following occurs:

- You are no longer disabled or you are deceased.
- You fail to provide proof of your disability in the required time period.
- You are no longer under the regular care of a physician or refuse the Insurance Company's request to be examined by a physician.
- You reach the end of the 26-week maximum benefit period.

**John's accident**

A year after joining APTIM as a Redstone Union employee, John was in a car accident and suffered serious injuries. After a hospital stay of three weeks, he was in a rehabilitation center for another two months before returning to work. Luckily, John had elected STD coverage so, during his 11 weeks of disability, John collected a weekly benefit of $160 for a total of $1,760 in STD benefits.

## Returning to work

When you are ready to return to work, contact your supervisor and APTIM Leaves. You may be required to provide a medical release from your doctor.

### *Vocational rehabilitation*

Depending on the restrictions of your disability, the Company may offer vocational rehabilitation to help you return to work in your current job or a different position. Vocational rehabilitation means employment or services that prepare you, if disabled, to resume gainful work.

Vocational rehabilitative services include, when appropriate, any necessary and feasible vocational testing, vocational training, work-place modification, prosthesis or job placement.

**John is back at work**

John was off work for 11 weeks, during which he recovered from severe injuries to his shoulder and legs from a car accident. His job required a lot of physical work, and John was not yet ready to handle that. The Company offered him training for a job that he could do on a computer while sitting at a desk. As a result, John was able to return to work much sooner than anticipated.

### *Rehabilitative employment*

You may participate in an approved program of rehabilitative employment while receiving STD benefits. The sum of your weekly benefit and total income received under the rehabilitative employment provision may not exceed 100% of your pre-disability weekly earnings. If this sum exceeds your pre-disability weekly earnings, the weekly benefit paid by the Company will be reduced proportionately. Your maximum period of rehabilitation payment is 6 months.

### *What if I become disabled after returning to work?*

STD benefits are payable on a per-occurrence basis. If you return to work as an active full-time or part-time employee working at least 20 hours a week or more and you become disabled again, it is considered a new occurrence and after meeting your elimination period, you will receive your full STD benefit for the new disability.

However, it will be treated as the same period of disability — and your 13-week maximum will not start again (and you will not need to meet a new elimination period) — if:

- Your disability is due to the same or a related cause; and
- You have been back at work as an active full-time or part-time employee working at least 20 hours a week for 30 consecutive days or less.

## When benefits are not paid

| Exclusions | |
|---|---|
| **STD benefits are not paid for disabilities resulting from …** | ▪ Commission of a crime for which you have been convicted under state or federal law.<br>▪ Cosmetic surgery that is not medically necessary.<br>▪ Injury as a result of working for pay or profit for another employer.<br>▪ Injury, sickness, mental illness or nervous disorder, substance abuse, or pregnancy that is not being treated by a physician.<br>▪ Intentional self-inflicted injury or attempted suicide.<br>▪ Occupational-related sickness or injury.<br>▪ Participation in a riot.<br>▪ War or act of war (declared or not). |
| **In addition, benefits will not be paid if …** | ▪ You are incarcerated.<br>▪ You lose your license that is a requirement of your job, unless it is due to a covered disability.<br>▪ You are eligible for benefits for a disability under a prior disability plan that:<br>– Was sponsored by the employer; and<br>– Was terminated before the effective date of this plan. |

## How to request benefits

If you become sick or injured and you think you are eligible for STD benefits, you must:

- Call Prudential, the Plan Administrator, at 1-800-842-1718;
- Contact APTIM Leaves; and
- Notify your supervisor or manager.

## Does collecting STD benefits affect my other APTIM benefits?

No. You will continue to be eligible for your other Company benefits, including medical and life insurance, while you are receiving STD benefits.

You will be billed for your portion of benefit premiums by Alight. All payments must be paid directly to Alight in order to continue Company benefits.

# Salary Continuation Plan/Short-Term Disability (STD)

The Salary Continuation Plan/Short-Term Disability (STD) provides payments to salaried employees who miss work due to medical necessity because of their own illness, injury, pregnancy or childbirth.

The plan is administered by Prudential. Prudential determines eligibility for the Salary Continuation Plan/Short-Term Disability (STD) based on medical criteria and certifies the period of medically justifiable absence.

Here are the plan basics:

| | |
|---|---|
| **Do I need to enroll?** | If you are eligible, you are automatically enrolled in the base coverage. If you want the "buy-up" coverage, you must enroll. |
| **Are my dependents eligible?** | No. The plan is for employees only. |
| **Who pays?** | The Company pays the cost of the base coverage and the employee pays for the "buy-up" coverage if elected. |
| **What is my benefit?** | You will receive a benefit payout of 100% of base pay up to the first 8 weeks and 50% of base pay for up to an additional 18 weeks. The employee-paid buy-up would then supplement 50% of your salary (up to $3,000) up to 18 additional weeks, paid by Prudential. Total payout will not exceed 26 weeks. The number of weeks you receive a benefit payout depends on your medical eligibility approval dates from Prudential. |

## Eligibility and enrollment

The *General Information* section contains most of the eligibility and enrollment information for the Company benefits. However, there are a few specific rules for the Salary Continuation Plan/Short-Term Disability (STD).

### *Am I eligible?*

You are eligible for the Salary Continuation Plan/ Short-Term Disability (STD) if you are a:

- Salaried full-time or salaried part-time employee; and
- You are regularly scheduled to work 20 or more hours per week and have since your first day of employment.

### *When and how does my coverage begin?*

You do not enroll in the plan. If you are eligible, you are automatically enrolled and your coverage begins on your date of hire.

## What does coverage cost?

The Company pays the full cost of your Salary Continuation Plan/Short-Term Disability (STD) coverage. You do not have to pay any premiums for coverage.

## How does the plan work?

Under this plan, if you miss work due to medical necessity because of your illness, injury, pregnancy or childbirth, your base pay continues, based upon medical eligibility approval dates from Prudential. Payments begin on the first day of absence from work, however you must be absent from work for at least 14 consecutive calendar days to be eligible. Your base pay is equal to your annual base salary, not including any bonuses, commissions, overtime pay, or other compensation.

| Duration | Benefit amount |
|---|---|
| **Up to the first 8 weeks of absence** | 100% of employee salary |
| **Up to 18 additional weeks** | 50% of employee salary |

If you are electing "buy-up" options for the first time, an EOI will be required. You will be notified during your enrollment if an EOI will be required.

**Bob hurts his back**

Bob, a salaried employee with the Company, fell off a ladder while cleaning his gutters and severely hurt his back. In fact, he was off work for 10 full weeks before he recovered enough to return. Prudential approved the full 10 weeks of medical eligibility. Under the Salary Continuation Plan/Short-Term Disability (STD) he was able to collect his full base pay for the first 8 weeks and half of his base pay for the last two weeks of his absence.

## Returning to work

The Company expects employees to return to work as soon as medically able. If you are not medically cleared to return to work after the period of maximum salary continuation/STD, you would be expected to use your remaining paid leave (e.g., vacation pay). After exhausting any remaining paid leave, you will not receive any pay unless you are eligible and enrolled for benefits under the Long-Term Disability (LTD) Plan.

✓ You may become eligible for LTD payments after six months of a qualifying disability absence. See the *Long-Term Disability Plan* section starting on page M-1 for details.

### *What if I become ill or injured again?*

If you become ill or injured after returning to work, the new absence will either be treated as a continuance of the original illness, injury, pregnancy or childbirth, or a new medical condition, depending on:

- The cause of the absence; and
- How much time separates the absences.

Periods of absence due to the same cause are considered the same period of absence, and qualify for one benefit payment period if separated by less than 30 days of active employment.

If the new medical condition is the result of a different cause, or if it occurs at least 30 days after the previous absence, the benefit period would start over.

**Bob's back problem comes back**

Take Bob from the example at left. He returned to work after receiving salary continuation/STD for three months. Unfortunately, three weeks after his return, he reinjured his back. He was out for another six weeks before he was able to return to work for good.

Because he had been back at work for less than 30 days, and the cause of his disability was the same bad back, after receiving medical eligibility approval from Prudential, Bob's salary continuation/STD payments started up in the amount of half of his base pay for the entire six weeks of this most recent absence.

## When benefits are not paid

| Exclusions | |
|---|---|
| **Salary continuation/STD does not apply for medical conditions resulting from …** | ▪ Commission of a crime for which you have been convicted under state or federal law.<br>▪ Cosmetic surgery that is not necessary.<br>▪ Injury as a result of working for pay or profit for another employer.<br>▪ Injury, sickness, mental illness or nervous disorder, substance abuse or pregnancy that is not being treated by a physician.<br>▪ Intentional self-inflicted injury or attempted suicide.<br>▪ Occupational-related sickness or injury.<br>▪ Participation in a riot.<br>▪ War or act of war (declared or not). |
| **In addition, benefits will not be paid if …** | ▪ You are incarcerated.<br>▪ You lose your license that is a requirement of your job, unless it is due to a covered disability.<br>▪ You are eligible for benefits for a disability under a prior disability plan that:<br>– Was sponsored by the employer; and<br>– Was terminated before the effective date of this plan. |

## How to request benefits

If you expect that your absence from work will exceed 14 calendar days, you must:

- Call Prudential, the Plan Administrator, at 1-800-842-1718;
- Contact APTIM Leaves; and
- Notify your supervisor or manager.

You must provide notification no later than your 15th day of absence. Prudential works with APTIM Leaves to determine eligibility for salary continuance.

## Does collecting salary continuation/STD affect my other APTIM benefits?

No. You will continue to be eligible for your Company benefits, including medical and life insurance, while you are receiving salary continuation/STD benefits. Your portion of benefit premiums will be deducted from your salary continuation/STD benefit payments.

## Tax considerations

Because the Company pays the full cost of the plan, your salary continuation/STD payments are considered taxable income, and are subject to your regular authorized salary deductions and taxes.

# Long-Term Disability (LTD) Plan



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

## Long-Term Disability (LTD) Plan

LTD coverage provides income replacement in the event you have an accident or illness that prevents you from being able to work for an extended period of time. The benefit, in combination with any federal or state government disability payments, provides up to 60% of your base pay once you have been disabled for 180 days (90 days for Redstone Union employees). Your employee group determines your coverage.

- If you are a salaried employee, you will receive Company-paid base LTD coverage of 50% of your base pay with the option to "buy-up" to 60%.
- If you are an hourly/craft employee, you can elect employee-paid LTD coverage of 60% of your base pay.
- If you are a Redstone Union employee, you will receive Company-paid LTD coverage of 66.67% of your base pay.

The LTD Plan is fully insured with Prudential, which we will refer to as the Insurance Company in this section of the SPD.

**Here are the LTD Plan basics:**

| | |
|---|---|
| **Do I need to enroll?** | If you are an eligible, salaried employee, you are automatically enrolled in the base coverage (50%). If you want the "buy-up" coverage (10%), you must enroll.<br>If you are an hourly/craft employee, you need to enroll for LTD coverage.<br>If you are a Redstone Union employee, you are automatically enrolled in the Company-paid coverage. |
| **Who pays?** | For salaried employees, the Company pays the cost of the base coverage (50%) and the employee pays for the "buy-up" coverage (10%) if elected.<br>Hourly/craft employees pay the entire cost of LTD coverage.<br>For Redstone Union employees, the Company pays for the cost of the coverage. |
| **What is the minimum benefit?** | $50 per month. |
| **What is the maximum benefit?**<br>*See page M-3.* | For salaried employees: $10,000 per month.<br>For hourly/craft employees: $5,000 per month.<br>For Redstone Union employees: $10,000 per month. |
| **What is the maximum period of coverage?**<br>*See page M-8.* | As long as you continue to be disabled until the later of your Social Security Normal Retirement Age or the maximum benefit period. If your disability begins after age 65, your benefit duration will be based on a sliding scale. Mental and nervous disabilities, as well as alcohol and substance abuse disabilities, are covered to a maximum of 24 months. |
| **What if I get other disability benefits?** | Your LTD benefits may be reduced if you receive disability income from other sources. See page M-4 for details. |

## What does coverage cost?

The Company pays the cost of base coverage (50%) for salaried employees. Hourly/craft employees — and salaried employees who elect the "buy-up" option — pay for LTD coverage through payroll deductions. Your first premium payment will be deducted from your paycheck as soon as administratively possible after coverage begins or, if during annual benefits open enrollment, the first pay period of the following calendar year.

Your contributions for coverage will be deducted from your paycheck on an after-tax basis. If you are receiving LTD benefit payments under the plan, you do not have to pay premiums for coverage.

If you are not actively at work on the date your Company-paid or employee-paid coverage is scheduled to begin (or scheduled to increase under the "buy-up" option), your coverage will take effect upon your return to active service.

✓ If you are electing "buy-up" options for the first time, an EOI will be required. You will be notified during your enrollment if an EOI will be required.

## How the LTD Plan works

If you are disabled and unable to work for more than 180 days (90 days for Redstone Union employees), you may be eligible for benefits from the LTD Plan. You qualify for benefits if:

- You are disabled, as described on page M-3.
- You have been disabled for 180 days (90 days for Redstone Union employees). That is the "elimination period."
- The Insurance Company has approved your claim for benefits.

## What is a disability?

You are considered disabled under the LTD Plan if you:

- Are unable to work due to illness or accidental injury;
- Are under the appropriate care and treatment of a physician and are complying with the requirements of such treatment; and
- Meet the following requirements:

| | |
|---|---|
| **During the 180-day (90 days for Redstone Union employees) elimination period and for the next 24 months** | ▪ You cannot perform the material duties of your regular occupation with the Company; and<br>▪ You are unable to earn more than 80% of your covered earnings from working in your regular occupation. |
| **After the first 24 months of disability** | ▪ You cannot perform the material duties of any occupation for which you have the training, education or experience; and<br>▪ You are unable to earn 60% or more of your covered earnings from working in your regular occupation. |

✓ **The Insurance Company may require proof of continued disability and covered earnings.**

### *Elimination period*

The first six months (90 days for Redstone Union employees) that you are disabled are considered your elimination period. You do not collect LTD benefits during this time. Your elimination period begins the day you become disabled.

## Plan benefit

Your LTD benefit depends on your employee group and the option you elect.

| If you are a … | And you choose … | Your LTD benefit is … | To a maximum of … |
|---|---|---|---|
| **Salaried employee** | Base (50%) coverage — the Company pays for this coverage (automatic enrollment) | 50% of your covered earnings | $10,000 per month |
| | Optional buy-up (60%) coverage — you pay for the additional coverage | 60% of your covered earnings | $10,000 per month |
| **Hourly/craft employee** | LTD (60%) coverage — you pay for this coverage | 60% of your covered earnings | $5,000 per month |
| **Redstone Union employee** | LTD (66.67%) coverage — the Company pays for this coverage (automatic enrollment) | 66.67% of your covered earnings | $10,000 per month |

The minimum benefit is $50 per month.

### *What is "covered earnings"?*

Covered earnings is your base pay rate in effect for the last complete payroll period before the start of your disability. It does not include bonuses, overtime pay, or any other extra compensation or income received from sources other than your employer.

Below is an example of how an LTD benefit is calculated.

**Thomas' LTD benefit**

Thomas is a salaried employee with optional buy-up (60%) LTD coverage who earned $7,500 the month before he suffered a stroke and became disabled. $450 of that was a bonus payment. Below is how his monthly benefit is calculated:

$ 7,050 covered earnings ($7,500 – $450)
x 60%
$ 4,230 LTD benefit

## Other income benefits

Your benefit may be offset by certain other disability income benefits. If you are eligible for these other benefits, your LTD benefit is reduced so that your total monthly benefit from all sources does not exceed what you would receive from the LTD Plan alone.

Below are just a few examples of other income benefits and how they affect your LTD benefit:

| Benefits that may offset LTD benefits | Benefits that *do not* offset LTD benefits |
|---|---|
| ▪ Social Security benefits.<br>▪ Worker's compensation.<br>▪ Local, state or federal government disability benefits.<br>▪ Sick leave or Salary Continuation Plan/Short-Term Disability (STD) benefits.<br>▪ Benefits from any retirement plans funded by the Company.<br>▪ Other group disability policies (for example, from another employer).<br>▪ The amount that you received, due to your disability, from a third party by judgment, settlement, or otherwise.<br>▪ The amount that you receive from a partnership, proprietorship or any similar draws.<br>▪ The amount that you receive or are entitled to receive under any unemployment income act or law due to the end of employment with your employer.<br>▪ The amount you receive under the maritime doctrine of maintenance, wages and cure. | ▪ Individual disability policies.<br>▪ 401(k) account distributions.<br>▪ Employee savings plans.<br>▪ "No fault" auto insurance. |

Any increases to the offset amounts as the result of cost of living or statutory changes will not further reduce your LTD benefit.

✓ You **must** apply for all other income benefits for which you may be eligible, and provide a statement of those amounts if requested by the Insurance Company. If you do not apply for all other income benefits, the Insurance Company has the right to reduce your benefit by the estimated amount of any other income benefits for which you may be eligible.

## If you return to work and become disabled again

If you return to work after you have been off due to disability, and then become disabled again, you may need to complete a new six-month elimination period before LTD benefits will be paid for the second disability. It depends on:

- Whether LTD benefits have already begun;
- How long you have been back at work; and
- Whether you are disabled from the same cause, or from a different cause.

| **If LTD benefits HAVE begun** *(This is the recurrent disability provision)* | | |
|---|---|---|
| **If you return to work and then …** | **You DO need to start a new elimination period if …** | **You DO NOT need to start a new elimination period if …** |
| **Become disabled again from the SAME cause** | You were back at work for 30 days or more. | You were back at work for less than 30 days. |
| **Become disabled again from a DIFFERENT cause** | You returned to work for any period of time. | Not applicable. |

✓ To prevent insurance overpayments because of any duplication of benefits, benefits payable under the recurrent disability provision will stop if you are eligible for benefits under any other group long-term disability policy.

**Jack's six-month wait**

Jack is a full-time employee and spent four months away from work recovering from a grueling surgery. A self-proclaimed "workaholic," Jack was happy when his doctor finally gave him the OK to go back to work. But after being back for just two weeks, he was in pain and his doctor put him back on bed rest.

Since he had returned to work for such a short period that he had not earned more than 80% of his covered earnings in that month and the new disability was from the same cause (the initial surgery), he does not have to start the countdown to six months all over again. He was not disabled while at work for those two weeks, so those days do not count toward his six-month elimination period. When he became disabled again after working for two weeks, he was considered four months into his elimination period.

## Work incentive benefit

The work incentive benefit is a feature of the LTD Plan that allows you to participate in a return to work program while you are receiving LTD benefits. If, while you remain disabled, you return to work in your regular occupation or a different position and earn less than 80% of your covered earnings, you can qualify for the work incentive benefit.

### *During the first 24 months*

Under the work incentive benefit, during the first 24 months of your disability period, you will receive:

- Your LTD monthly benefit; plus
- Your earnings from your occupation.

If your income from your work earnings plus your LTD benefit add up to more than 100% of your covered earnings, the LTD benefit will be reduced by the amount in excess of 100%.

Here is how it worked for Thomas, from the example on page M-4:

**Work incentive benefit motivates Thomas' return**

Two years after his stroke, Thomas recovered enough to get back to the office. He was able to resume working at his regular occupation but at only one quarter of his regular schedule. Under the work incentive benefit, his total monthly earnings are:

| | |
|---|---|
| $ 4,230.00 | monthly LTD benefit |
| + 1,762.50 | monthly earnings from his occupation |
| $ 5,992.50 | total monthly income |

Thomas' total monthly income of $5,992.50 does not exceed his covered earnings of $7,050, so his LTD benefit does not need to be reduced.

### *After the first 24 months*

If, after the 24-month work incentive period, you continue to work even on a part-time basis, whether at your own occupation or at a new one, you will receive your LTD monthly benefit less 50% of your return to work earnings and any other income benefits as detailed on page M-4.

**Thomas continues working while disabled**

Thomas was still disabled after his 24-month work incentive period expired. He was not well enough to handle a full-time schedule, but he enjoyed keeping active and staying connected to his work, and his department valued his skills and experience. He submitted his proposed work schedule to the Insurance Company, and now Thomas' monthly earnings from his LTD benefit are:

| | |
|---|---|
| $ 4,230.00 | monthly LTD benefit |
| – 881.25 | 50% of his monthly $1,762.50 earnings from his occupation |
| $ 3,348.75 | new monthly LTD benefit |

## Survivor benefit

If you die while receiving benefits under the LTD Plan, your eligible survivor(s) will receive a lump-sum benefit equal to **three times the lesser of**:

- Your monthly LTD benefit for which you were eligible in the full month before the month in which you die — plus any amount by which your benefit had been reduced that month due to return to work earnings; or
- The maximum monthly benefit of $10,000 for salaried employees or $5,000 for hourly/craft employees.

The survivor benefit is paid to the first eligible survivor(s) listed below who is living at the time of your death:

1. Your lawful spouse/domestic partner (DP), if you are married at the time of your death; otherwise
2. Your children (including stepchildren), who are unmarried, under age 21, and dependent upon you for support and maintenance, in equal shares; otherwise
3. Your estate.

### What happens to my other Company benefits?

You may be eligible to continue medical, prescription drug, EAP, dental and/or vision coverage through COBRA. For more information on COBRA, see "How to continue coverage" in the *Benefit Rights* section starting on page R-10.

### Tax considerations

Any benefits received under the LTD Plan are tax-free. However, for salaried employees, the Company-paid premiums for base LTD (50%) coverage are considered "imputed income." Imputed income is added to your total annual compensation reported to the IRS, appears on your W-2 statement and is taxable at your regular income tax rate on a per-pay-period basis.

## How to request benefits

If you have been sick or injured and you think you are eligible for benefits under the LTD Plan, contact Prudential at 1-800-842-1718.

## When benefits end

You will continue to be eligible for benefit payments from the LTD Plan as long as you remain disabled, as determined by the Insurance Company. However, all payments end when any of the following occurs:

- The date you are no longer disabled or you die. (Your survivor may be eligible for a lump-sum benefit — see "Survivor benefit" on page M-6.)
- The date you fail to provide satisfactory proof of continuing disability.
- The date you do not have a medical examination as required by the LTD Plan.
- The date your current earnings exceed 80% of your covered earnings during the first 24 months of disability, or 60% of your covered earnings after 24 months of disability. If you are participating in the work incentive program, the benefit will be based on the work incentive calculation (see page M-6).
- The date no further benefits are payable under the LTD Plan.
- The date you refuse to participate in a work incentive program or refuse to try modifications to the work site or job process.
- The date you refuse recommended treatment that is generally acknowledged by physicians to improve the disabling condition.
- The date you reach the maximum benefit period shown on page M-8.
- If, at any time, you decline to take part in or cooperate in a rehabilitation evaluation/assessment or program that Prudential feels is appropriate for your disability and that has been approved by your doctor.

## Maximum benefit period

The maximum benefit period is the later of your SSNRA* or the maximum benefit period listed below.

| Your age on date disability begins | Your maximum benefit duration |
|---|---|
| **Under age 61** | To your normal retirement age*, but not less than 60 months |
| **Age 61** | To your normal retirement age*, but not less than 48 months |
| **Age 62** | To your normal retirement age*, but not less than 42 months |
| **Age 63** | To your normal retirement age*, but not less than 36 months |
| **Age 64** | To your normal retirement age*, but not less than 30 months |
| **Age 65** | 24 months |
| **Age 66** | 21 months |
| **Age 67** | 18 months |
| **Age 68** | 15 months |
| **Age 69 and over** | 12 months |

** Your Social Security normal retirement age is your retirement age under the Social Security Act where retirement age depends on your year of birth.*

# When benefits are not paid

There are some instances in which LTD benefits are not payable. The table below lists situations and conditions in which benefits are limited or excluded from coverage.

| **Limitations** | |
|---|---|
| **Mental/nervous disorders, alcoholism or drug abuse** | Benefits are limited to a lifetime maximum of 24 months for a disability caused by, or contributed to by, any one or more of the following conditions: anxiety disorders, delusional (paranoid) disorders, depressive disorders, eating disorders, mental illness, somatoform disorders (psychosomatic illness), alcoholism, or drug abuse. If you are confined in a hospital for more than 14 consecutive days for a mental/nervous disorder, alcoholism, or drug abuse before reaching the lifetime maximum, that period of confinement will not count against the 24-month maximum. |
| **Pre-existing conditions** | Benefits will not be paid for a disability caused by an illness or injury for which you received medical care, including prescription drugs, in the three months prior to your effective date of coverage. The pre-existing condition limitation will apply to any increase in benefits (for example, salaried employees who choose the optional buy-up coverage). This limitation will not apply to a period of disability that begins after you are covered for at least 12 months after your effective date of coverage (or the effective date of any increase in benefits). |
| **Exclusions** | |
| **LTD benefits are not paid for disabilities resulting from …** | ▪ Commission of a crime for which you have been convicted under state or federal law.<br>▪ Intentional self-inflicted injury or attempted suicide.<br>▪ Participation in a riot.<br>▪ War or act of war (declared or not). |
| **In addition, benefits will not be paid if …** | ▪ You are incarcerated.<br>▪ You lose your license that is a requirement of your occupation, unless it is due to a covered disability.<br>▪ You are eligible for benefits for a disability under a prior disability plan that:<br>– Was sponsored by the employer; and<br>– Was terminated before the effective date of the LTD Plan. |

# Identity Theft Protection Plan



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

## Identity Theft Protection Plan

Identity Theft Protection is an affordable solution to a growing concern. It provides comprehensive, proactive identity theft monitoring and dedicated recovery assistance. By constantly monitoring your personal and financial data, this service catches fraud early and helps you act quickly to limit the damage caused by stolen information. Allstate Identity Protection is the administrator for APTIM's Identity Theft Protection Plan.

## Eligibility

You must enroll to participate. See the *General Information* section starting on page A-1 for more information about eligibility and enrollment.

## Important features

The Identity Theft Protection Plan provides active monitoring of your:

- Social Security number, names, addresses, emails, and date of birth.
- Social media reputation monitoring, tri-bureau credit alerts, and dark web monitoring.
- Login credentials including emails and passwords.

The plan offers a $1 million Identity Theft Protection Policy, which reimburses out-of-pocket costs associated with identity theft, including lost wages, legal fees, funds stolen out your H.S.A., bank account, or 401(k) Plan, and more.

## Using your benefit

Participants have access to Privacy Advocates. These advocates act as dedicated case managers and are available to answer questions, offer additional identity protection tips, discuss plan features, and provide technical assistance.

They can also help with making claims and managing the restoration process.

Restoration services can include:

- Criminal;
- Tax; and
- Other forms of identity theft.

## How to enroll

You will have the opportunity to enroll or disenroll in the Identity Theft Protection Plan each year during annual benefits open enrollment. The coverage you elect during annual benefits open enrollment will remain in effect until the following plan year as long as you remain eligible.

Once you have enrolled, you will receive a welcome letter or email from Allstate Identity Protection, which will include your Member ID. In order to utilize key features available to you upon enrollment, you must first set up your account online. To set up your account:

1. Log on to https://www.myaip.com. You will need your Member ID provided in the welcome letter or email to start the setup process.
2. Activate credit monitoring. This will activate Allstate Identity Protection's highest level of threat monitoring.
3. If you are enrolled in family coverage, register your dependents to ensure they are protected as well.

For any questions, please contact one of our Privacy Advocates by calling 1-800-789-2720 or emailing customercare@aip.com. Representatives are available 24 hours a day, 7 days a week.

# Accident Insurance



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

## Accident Insurance

Accident Insurance can help cover the out-of-pocket medical expenses and extra bills that can follow an accident. The total benefit you receive is based on the type of injury, its severity and the medical services you received in treatment and recovery.

The Plan pays benefits for a variety of injuries and accident-related expenses.

Examples of covered injuries include:

- Fractures
- Dislocations
- Hospitalization
- Physical Therapy
- Emergency Room Treatment
- Transportation

## Eligibility

You must enroll to participate. See the *General Information* section starting on page A-1 for more information about eligibility and enrollment.

*The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that may affect any benefits payable.*

## Important features

Features of the Accident Insurance Plan include:

- Benefits paid for accidents that occur on or off the job.
- You can elect to cover your enrolled spouse/domestic partner (DP) and children.
- There are no health questions or physical exams required.
- Coverage is portable, which means you can take your policy with you if you change jobs or retire.

## Using your benefit

Accident insurance provides you with a lump-sum payment — one convenient payment all at once — that can help you pay for costs that aren't covered by your medical plan.

The payment is made directly to you, and is in addition to any other insurance you may have. It's yours to spend however you like, including for your or your family's everyday living expenses.

For any questions, general services, or to file a claim, please contact Prudential at 1-844-455-1002, Monday through Friday from 7 a.m. to 7 p.m. CT.

## How to enroll

You will have the opportunity to enroll or disenroll in Accident Insurance each year during annual benefits open enrollment. The coverage you elect during annual benefits open enrollment will remain in effect until the following plan year as long as you remain eligible.

# Hospital Indemnity Insurance



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

## Hospital Indemnity Insurance

Hospital Indemnity Insurance pays a benefit directly to you if you or a covered family member receives hospital care. You receive a benefit for being admitted to the hospital and then for each day you're confined. Additional benefits are paid based on the type of services you receive. Emergency room services are also eligible.

*The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that may affect any benefits payable.*

## Important features

Features of Hospital Indemnity Insurance include:

- Benefits are paid regardless of any other insurance you have.
- No physical exams are required to enroll for coverage.
- Coverage is available for your eligible spouse/domestic partner (DP) and children.
- Premiums are paid through convenient payroll deductions.

For questions, general services, or to file a claim, please contact Prudential at 1-844-455-1002, Monday through Friday from 7 a.m. to 7 p.m. CT.

## How to enroll

You will have the opportunity to enroll or disenroll in Hospital Indemnity Insurance each year during annual benefits open enrollment. The coverage you elect during annual benefits open enrollment will remain in effect until the following plan year as long as you remain eligible.

# Critical Illness Insurance



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

Critical Illness Insurance provides financial protection for any covered individual or family member to supplement existing medical coverage and help with out-of-pocket expenses such as mortgage payments, college tuition, or treatments not covered by your medical plan.

## Eligibility

You must enroll to participate. See the *General Information* section starting on page A-1 for more information about eligibility and enrollment.

*The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that may affect any benefits payable.*

## Important features

Features of Critical Illness Insurance include:

- Supplemental coverage for medical emergencies such as heart attack, stroke, cancer and more.
- Lump-sum benefit for covered employees and family members.
- Access to discounts or services through Prudential.
- No coordination with other insurance benefits.
- Eligibility for portability (subject to eligibility requirements and limitations).
- Health Screening Benefit

## Using your benefit

You have the choice of $10,000, $20,000, or $30,000 in Guaranteed Issue coverage. Coverage for your spouse/domestic partner (DP) is 100%, and your dependent children will be offered 50% of your employee benefit amount.

## How to enroll

You will have the opportunity to enroll or disenroll in Critical Illness Insurance each year during annual benefits open enrollment. The coverage you elect during annual benefits open enrollment will remain in effect until the following plan year as long as you remain eligible.

## Who pays?

The employee pays the full cost of the benefit. Rates increase with age and if you are a tobacco user. This benefit has an issue-age rate structure.

# Benefit Rights



If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

## Disclaimer

This handbook describes the health and welfare benefit plans available to eligible employees of APTIM. It does not include all plan details.

All sections of this handbook, when combined, form the Summary Plan Description (SPD). The SPD describes the major provisions of the plans. It does not replace the official plan documents or insurance policies which govern each of the respective plan's operations. In the case of any conflict between the SPD and the official plan documents or insurance policies, the plan documents or insurance policies will govern.

✓ Copies of official plan documents, the latest annual reports and any other legally required materials under which a plan is operated, may be obtained free of charge by written request to the Plan Administrator.

**For convenience, the word "plan" may be used to refer to any and/or all of the benefit plans outlined in this SPD as appropriate.**

## Plan names and number

The APTIM Health and Welfare Benefit Plan will be filed on a single Form 5500 under plan number 501.

| Benefits | Official plan name |
|---|---|
| ▪ **Medical**<br>▪ **Prescription drug**<br>▪ **HSA**<br>▪ **Dental**<br>▪ **EAP**<br>▪ **Vision** | APTIM Medical Plan |
| ▪ **Life insurance**<br>▪ **AD&D** | APTIM Life Insurance Plan |
| **Travel accident** | APTIM Travel Accident Insurance Plan |
| **LTD** | APTIM Long-Term Disability Plan |
| **Cafeteria plan (allows certain plans' employee premiums to be paid on a before-tax basis)** | APTIM Cafeteria Plan |
| **FSAs** | APTIM Health Care Flexible Spending Account Plan and<br>APTIM Dependent Care Flexible Spending Account Plan |
| **STD** | APTIM Hourly Employees Short-Term Disability Plan |
| **Salary continuation** | N/A — Company payroll practice |

## Plan identification information

The official Plan Sponsor and Employer Identification Number for all plans are:

APTIM Corp.
4171 Essen Lane
Baton Rouge, LA 70809
Phone: 1-225-932-2500
EIN number: 82-0889816

## Plan Administrator

APTIM Corp.
4171 Essen Lane
Baton Rouge, LA 70809
Phone: 1-225-932-2500

The Plan Administrator has delegated its authority and discretion regarding claims to the Claims Administrators (see below), by agreement or administrative contract with the Claims Administrators, or if none, by this provision of the plan.

## Claims Administrators

The Plan Administrator delegates its claims processing authority to Claims Administrators for the various benefit plans. The respective Claims Administrators have full and absolute discretion to determine the eligibility for and amount of benefits due or payable under the plans, or to otherwise interpret and apply the terms of the plans. Their decisions are final and binding on all parties. The Claims Administrators are:

| Benefits | Claims Administrator | Contact information |
|---|---|---|
| **Employee Assistance Program (EAP)** | ComPsych GuidanceResources Worldwide | 1-866-207-5157 (U.S.)<br>1-866-641-3847 (Canada)<br>https://www.guidanceresources.com/groWeb/login/login.xhtml<br>Web ID: **APTIM** |
| **Medical and Prescription Drug** | Elected Carrier | See the *Contacts* section starting on page R-1 |
| **Health Savings Account (HSA)** | Bank of America | 1-866-791-0250 |
| **Dental** | Elected Carrier | See the *Contacts* section starting on page R-1 |
| **Vision** | Elected Carrier | See the *Contacts* section starting on page R-1 |
| **Flexible spending accounts (FSAs)** | Alight Smart-Choice Accounts™ | 1-833-476-2342 and follow the prompts |
| ▪ **Life insurance**<br>▪ **Accidental death and dismemberment (AD&D)** | Prudential | Prudential<br>1-800-842-1718<br>ABS Phone: 1-877-367-7781<br>www.prudential.com/mybenefits |

*(continued)*

| Benefits | Claims Administrator | Contact information |
|---|---|---|
| **Travel accident** | AIG | AIG Claims Dept<br>P.O. Box 25987<br>Shawnee Mission, KS 66225-5897<br>Toll-Free/Free Phone (within the U.S.):<br>1-877-244-6871<br>Collect/Reverse Charge (outside the U.S.):<br>+1-715-346-0859<br>Email: assistance@aig.com |
| **Salary continuation** | APTIM | leaves@aptim.com |
| ▪ **Short-term disability (STD)**<br>▪ **Long-term disability (LTD)** | Prudential | Prudential<br>1-800-842-1718<br>ABS Phone: 1-877-367-7781<br>www.prudential.com/mybenefits |

## Insured benefits *(NOTE: Vision and Travel Accident are insured)*

The Company provides life and AD&D insurance, travel accident insurance, long-term disability and short-term disability benefits through the purchase of insurance policies. Your eligibility and claims for benefits under these plans will be determined by the terms of the insurance policies. For these benefit plans, the insurers are as follows:

| Official plan names | Insurer |
|---|---|
| **APTIM Life Insurance Plan** | Prudential<br>1-800-842-1718<br>ABS Phone: 1-877-367-7781<br>www.prudential.com/mybenefits |
| **APTIM Travel Accident Insurance Plan** | AIG<br>P.O. Box 25987<br>Shawnee Mission, KS 66225-5897 |
| ▪ **APTIM Long-Term Disability Plan**<br>▪ **APTIM Hourly Employees Short-Term Disability Plan** | Prudential<br>1-800-842-1718<br>ABS Phone: 1-877-367-7781<br>www.prudential.com/mybenefits |

## Plan year

The plan year for all benefit plans is January 1 through December 31.

## Cafeteria Plan

The APTIM Cafeteria Plan, adopted pursuant to Section 125 of the Internal Revenue Code, provides you the opportunity to make required contributions toward certain benefit plans on a before-tax basis, which means that your premiums are deducted before federal and state income and Social Security taxes are withheld. (**Note:** New Jersey does not recognize before-tax deductions, so in New Jersey, only your federal taxable income would be affected.)

You may pay your share of the cost of the following benefits on a before-tax basis as an active employee:

- Medical and prescription drug.
- Dental.
- Vision.
- Health Savings Account (HSA).
- Flexible spending accounts (FSAs).

**An election to participate in any of these benefits is deemed to be an election to participate in the Cafeteria Plan.**

The following important restrictions apply under the Cafeteria Plan:

- You may not revoke, begin or change your election during the year for medical, dental or vision coverage unless the revocation, new election or change is as a result of a qualifying life event and is otherwise allowed under the plan. For more information, see "Qualifying life events" in the *General Information* section.
- You also cannot stop or change the amount you contribute to an FSA during the year unless certain qualifying life events occur. For additional information on when you may be eligible to make changes to your FSAs, see "Qualifying life events" in the *Flexible Spending Accounts (FSA)* section.
- You can start or discontinue contributions or change the amount you contribute to your HSA during the year, up to IRS limits. See the *Health Savings Account (HSA)* section for details.

**Cafeteria Plan's effect on Social Security**

Before-tax benefit plan contributions will reduce future Social Security benefits for employees earning under the maximum amount to which FICA taxes apply. However, under the current Social Security structure, the expected reduction should be only a few dollars per month and should be more than offset by the value of the current tax savings. You should consult a tax or financial advisor if you have concerns about how Cafeteria Plan benefits may affect your future Social Security benefits.

## Plan amendment or termination

It is the present intent of the Company to continue the health and welfare benefit plans in their current form. However, the Company cannot guarantee that the plans will continue indefinitely, or without change in either the level of benefits, events covered or contribution required of participating employees. The Company reserves the right to make such changes or amendments — or to terminate any benefit plans — at any time and for any reason, either by action of the Board of Directors of the Company, or by any person or body to whom the directors have delegated its authority. If an amendment to a Company-sponsored benefit plan should occur, any benefits received or applied for before the amendment will not be reduced or eliminated.

Participation in the benefit plans, or the extent of coverage of such plans, is not and shall not be guaranteed to any employee based on employment with the Company, length of service or retirement.

## No right to employment

Your eligibility for or right to benefits under the benefit plans is not a guarantee of continued employment. APTIM reserves the right to terminate your employment at any time and for any reason, in accordance with state and federal laws.

## Address changes

In order to protect your family's rights, you should keep the Company informed of 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 through the APTIM Benefits Marketplace or otherwise.

## Foreign assignments

Contact your local Human Resources office for information regarding coverage while on foreign assignment.

## Funding

| Benefits | Funding |
|---|---|
| ▪ **Medical (including prescription drug coverage)**<br>▪ **Dental** | ▪ The cost of benefits is shared by the Company and enrolled participants.<br>▪ This is a fully insured benefit, and benefits are paid by the Claims Administrator. |
| **Vision** | ▪ Covered employees pay the full cost of coverage.<br>▪ This is a fully insured benefit, and benefits are paid by the Claims Administrator. |
| **Health Savings Account (HSA)** | ▪ Employees who elect HSA coverage fully fund their own health care spending account.<br>▪ The Company pays the Claims Administrator to administer benefits under the HSAs. |
| **Employee Assistance Program (EAP)** | ▪ Fully funded by the Company. |
| **Flexible spending accounts (FSAs)** | ▪ Employees who elect FSA coverage fully fund their own flexible spending account(s).<br>▪ The Company pays the Claims Administrator to administer benefits under the FSAs. |
| ▪ **Life insurance**<br>▪ **AD&D**<br>▪ **Travel accident** | ▪ These are fully insured benefits, and benefits are paid by the Claims Administrator.<br>▪ The Company pays the full cost for basic life, AD&D and travel accident insurance coverage.<br>▪ Eligible employees who elect optional life and/or optional AD&D insurance coverage pay the full cost of those coverages. |
| **Short-term disability (STD)** | ▪ This is a fully insured benefit, and benefits are paid by the Claims Administrator.<br>▪ Covered employees pay the full cost of coverage. |
| **Long-term disability (LTD)** | ▪ This is a fully insured benefit, and benefits are paid by the Claims Administrator.<br>▪ The Company pays the full cost for base (50%) LTD coverage for salaried employees.<br>▪ Eligible salaried employees who elect "buy-up" (60%) LTD coverage pay for the additional coverage.<br>▪ Eligible hourly employees who elect LTD (60%) coverage pay the full cost of coverage. |
| **Salary continuation** | ▪ This is a Company payroll practice — the Company pays benefits as they occur.<br>▪ The Company has an "administrative services only" agreement with the Claims Administrator. |

## Legal process

The agent for service of legal process is:

APTIM General Counsel
APTIM Corp.
4171 Essen Lane
Baton Rouge, LA 70809
Phone: 1-225-932-2500

Legal process also may be served on the Plan Administrator.

## Your ERISA rights

As a participant in the Medical Plan (including EAP), Life Insurance Plan, Travel Accident Plan, Long-Term Disability Plan, Health Care FSA and/or Hourly Employees Short-Term Disability Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and worksites, all plan documents, insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the Internal Revenue Service or the U.S. Department of Labor such as detailed annual reports (Form 5500) and plan descriptions, under which the plan is operated.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse/domestic partner (DP) or dependents if there is a loss of coverage under the plans as a result of qualifying event. You and your dependents may have to pay for such coverage. Review this SPD and the documents governing the plans on the rules governing your COBRA continuation coverage rights.

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

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you have a claim, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. If, after you have submitted a written request to the Plan Administrator for materials the plan is required by law to have, and have not received such materials within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have questions about your rights under ERISA, you should contact the nearest area office of the U.S. Labor-Management Service Administration, Department of Labor.

## Assignment of benefits

**The plan contains an anti-assignment provision. This provision provides that you and your dependents do not have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you or your dependents may expect to receive, contingently or otherwise, under the plan.**

## Right of recovery, subrogation and reimbursement

The plans have a right of recovery, subrogation and reimbursement as outlined in this section.

### Right of recovery

If a benefit larger than the amount allowed by the plan is paid, the plan has the right to require the return of the overpayment. The plan also has the right to reduce any future benefit payments made to you or on behalf of you by the amount of the overpayment.

### Subrogation

The plan does not cover expenses incurred by a plan participant for which another party may be responsible because the other party caused or contributed to the participant's injury or sickness. If, in the opinion of the plan or its Claims Administrator, another party is responsible for a payment:

- The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a participant may have against the responsible party.
- The plan shall automatically have a lien upon the proceeds of any recovery by a participant from the responsible party to the extent of any benefits paid under the plan.
- A participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.

### Right of reimbursement

The plan is also granted a right of reimbursement from the proceeds of any recovery by settlement, judgment or otherwise that are due to the plan. You or any other plan participant is required to reimburse the plan for any expenses to which the plan is entitled but for which you receive a payment directly or indirectly from a third party (or as a result of a settlement, judgment or arbitration award) in connection with:

- Automobile medical insurance.
- Automobile no-fault insurance.
- Uninsured or underinsured motorist.
- Homeowners' insurance.
- Workers' compensation.
- Government insurance (other than Medicaid).
- Any other similar type of insurance or coverage.

## Lien of the plan

By accepting benefits under the plan, you:

- Grant a lien and assign to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of you, as well as the costs and expenses, including attorney's fees, incurred by the plan with respect to any claim for reimbursement or subrogation. This is binding on any attorney or other party who represents you.
- Agree that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest in that recovery.
- Agree to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.
- May not incur any expenses on behalf of the plan in pursuit of the plan's recovery rights, specifically:
  - No court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the Plan Administrator.
  - This right shall not be revoked by any so-called "Fund Doctrine," "Common Fund Doctrine" or "Attorney's Fund Doctrine."

In addition, the plan's right of recovery may not be reduced or revoked by any so-called "Made-Whole Doctrine," "Rimes Doctrine" or any other doctrine claiming to revoke the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

## Administrative rights

To administer claims, the Claims Administrator, without the consent of any person, has the right:

- To provide or obtain data needed to determine benefits under the plan.
- To recover any amount paid in excess of the plan's actual liability.
- To reimburse any organization an amount for benefits due. Amounts paid by the Claims Administrator will be considered benefits paid under the plan — and once paid, there will be no more liability under the plan for those benefits.

## Additional provisions

- You may not assign any rights of recovery for benefits to your minor dependent(s) without the prior express written consent of the plan. The plan's right of reimbursement applies to decedents', minors' and incompetent or disabled persons' settlements or recoveries.
- You may not make any settlement that specifically reduces or excludes — or attempts to reduce or exclude — the benefits provided by the plan.
- The plan's right of recovery and right of reimbursement will not be reduced due to your negligence or other fault.
- In the event that you fail or refuse to follow these rights of recovery, subrogation and reimbursement:
  - In the event you, your spouse/DP, your dependents, attorney, beneficiary, estate or third party distribute funds without regard to the plan's rights of subrogation or reimbursement, such individual or individuals will be personally liable to the plan for the amounts so distributed.
  - The plan will be entitled to recover any costs incurred in enforcing its rights including, but not limited to, attorney's fees, litigation, court costs and other expenses.
  - The plan will be entitled to reduce any future benefit payments until you have fully complied with your obligations.
- Your failure to cooperate with the plan under these provisions is considered a breach of contract. As such, the plan has the right to terminate your benefits, deny future benefits or take legal action against you. By accepting benefits under the plan, you agree that a breach of these provisions would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

## Qualified Medical Child Support Orders

A Qualified Medical Child Support Order or "QMCSO" is a court order that creates or recognizes the right of your dependent child to be covered under a group health plan in which you are enrolled (or in which you are eligible to enroll). Your dependent child under a QMCSO is referred to as an "alternate recipient."

A medical child support order is only considered "qualified" — and thus binding on the plan — if it includes all of the following information:

- The name and last known mailing address of the employee and each alternate recipient.
- A reasonable description of the type of coverage or benefits provided by the applicable health care plan to each alternate recipient.
- The period of time to which the order applies.
- The identification of each health care plan to which the order applies.

The QMCSO cannot require the plan to provide any benefits that it does not currently provide. The Plan Administrator will determine whether or not the medical child support order is qualified. If you terminate employment when a QMCSO is in effect, the alternate recipient(s) is entitled to continuation coverage under COBRA (see "COBRA continuation coverage" beginning on this page).

If you refuse to elect or continue dependent child coverage after the Plan Administrator has determined and notified you that the medical child support order is qualified, the Plan Administrator will enroll the alternate recipient in the appropriate health care coverage (and also enroll you, if you are not already enrolled in the plan(s)), and your contributions for coverage will be adjusted.

✓ For a copy of the plan's procedures for handling QMCSOs, available free of charge, contact the Plan Administrator.

## How to continue coverage

The plan has several options that may allow you and your dependents to continue medical, prescription drug, EAP, dental, vision and/or FSA coverage after the coverage would otherwise end under the terms of the plans. You will receive conversion notices for your applicable policies and can convert those to personal policies if you choose.

### COBRA continuation coverage

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if you or a covered dependent would otherwise lose coverage under a group health plan (providing medical, prescription drug, EAP, dental or vision benefits) due to a "qualifying event," you are eligible to continue that coverage for a limited period of time. You and your dependents who are eligible for COBRA are called "qualified beneficiaries."

**Health Care FSA COBRA continuation**

If you are enrolled in a Health Care Flexible Spending Account (FSA), you may also be eligible to continue your Health Care FSA participation for the remainder of the plan year under COBRA rules. Contributions for continuation of coverage will be on an after-tax basis and will include a 2% administrative fee — but continuing your coverage will help you avoid forfeiting funds you have contributed to your account but have not yet claimed. The amount you pay to continue coverage must be less than the remaining benefits you can receive under the Health Care FSA.

For more information on continuing your Health Care FSA through COBRA and an example of how it works, see the *Flexible Spending Accounts (FSA)* section starting on page F-1 or call the COBRA Administrator.

### *Qualifying events*

Only "qualified beneficiaries" are entitled to elect COBRA continuation coverage. You and your covered dependents are considered qualified beneficiaries if one of the following qualifying events occurs:

| COBRA qualifying events for you (the employee) | COBRA qualifying events for your covered spouse/DP and dependent children |
|---|---|
| ▪ Your hours of employment are reduced.<br>▪ Your employment ends for any reason other than your gross misconduct.<br>▪ Your failure to return to work at the end of an FMLA leave period. The last day of the leave period is the date of the qualifying event.<br>▪ Prior to the expiration of an FMLA leave period, your notification to the Company that you will not be returning to work. The date the Company receives your notification is the date of the qualifying event. | ▪ You die.<br>▪ Your hours of employment are reduced.<br>▪ Your employment ends for any reason other than your gross misconduct.<br>▪ You become entitled to Medicare benefits (under Part A, Part B or both).<br>▪ You become divorced or legally separated from your spouse/DP.<br>▪ Your dependent child is no longer an eligible dependent under the plan. |

***A qualifying event occurs on the date of the qualifying event — not on the date in which coverage ends because of the qualifying event.***

### *Qualified beneficiaries*

As an employee, you become a qualified beneficiary if you lose your coverage as the result of a qualifying event. Generally, your spouse/DP and dependent children can only become qualified beneficiaries if they were covered by the plan at the time of the qualifying event. However, under COBRA, a child who is newly born or placed for adoption during the period of COBRA continuation coverage may be added as a covered dependent.

- You must add the new dependent within 31 days after birth or adoption via the APTIM Benefits Marketplace website or by calling the APTIM Benefits Marketplace.
- If you fail to add the new dependent within this 31-day period, the child cannot be added until the next annual benefits open enrollment period.

✓ Only persons described in this section can be qualified beneficiaries for purposes of COBRA. If you add another dependent to your coverage (such as a new spouse/DP due to marriage — or any other eligible dependent during an annual open enrollment period), that person will have the status of a dependent under the COBRA plan, but will not have the rights of a COBRA "qualified beneficiary."

**Example: Suzy's life events that qualify for COBRA**

Suzy is an employee who has enrolled herself, her husband and her three children in her Company medical and dental coverage.

- Suzy and her husband divorce, and her husband is no longer eligible for plan coverage. The divorce is the qualifying event. Her husband is the qualified beneficiary.
- Suzy's oldest daughter just turned 26, which makes her too old to be an eligible dependent under the plan. Her birthday is the qualifying event and her daughter is now a qualified beneficiary.
- Suzy leaves APTIM, and coverage under the plan ends for her entire family. Suzy's employment ending is the qualifying event. Suzy, her husband and her covered children are all qualified beneficiaries.

### *COBRA coverage periods*

Coverage may be continued under COBRA for all qualified beneficiaries as outlined below.

| Qualifying event | Maximum length of COBRA coverage | Special notes |
|---|---|---|
| ▪ **Your reduction in hours of employment, which disqualifies you from benefit eligibility.**<br>▪ **Your termination of employment (other than for your gross misconduct).** | 18 months from the date of the qualifying event. | This 18-month maximum benefit period applies to you and your covered dependents who are qualified beneficiaries. |
| **If a qualified beneficiary:**<br>▪ **Is disabled at the time your work hours are reduced or you terminate employment; or**<br>▪ **Becomes disabled within the first 60 days of the original 18-month COBRA period.** | 29 months (the original 18-month COBRA period plus an additional 11 months). The qualified beneficiary must remain disabled until at least the end of the original 18-month period. | ▪ The qualified beneficiary must be determined to be disabled by the Social Security Administration.<br>▪ You or your covered dependent must notify the COBRA Administrator within 60 days of the determination of disability to be eligible for this extension of coverage. |
| **A second qualifying event that occurs during the original 18-month COBRA period. Qualifying events include:**<br>▪ **Your death.**<br>▪ **Your divorce or legal separation.**<br>▪ **Your dependent child is no longer an eligible dependent under the plan.**<br>▪ **Your termination of employment or reduction in hours within 18 months of your entitlement to Medicare (under Part A, Part B or both).** | 36 months (the original 18-month COBRA period plus an additional 18 months). | ▪ Only your covered spouse/DP and dependent children are eligible for the additional 18 months of COBRA coverage under this provision.<br>▪ If the second qualifying event is your termination or reduction in hours within 18 months of your entitlement to Medicare, the 36-month period runs from the date you became entitled to Medicare.<br>▪ You or your covered dependent must notify the COBRA Administrator within 60 days of the qualifying event to be eligible for this extension of coverage. |

### *Notification of a qualifying event*

When the Plan Administrator has been notified that a qualifying event has occurred, you and/or any other qualified beneficiaries will be notified of your and/or their COBRA election rights. The Company will notify the Plan Administrator within 30 days of:

- Your reduction of hours of employment.
- Your termination of employment.
- Your death.
- Your becoming entitled to Medicare (Part A, Part B or both).
- Commencement of a bankruptcy proceeding.

You or your covered dependent are required to notify the Plan Administrator (via the APTIM Benefits Marketplace website or by calling the APTIM Benefits Marketplace) within 60 days of:

- Your divorce or legal separation.
- Your dependent child no longer meeting the eligibility requirements under the plan.
- A determination of disability by the Social Security Administration.

**If you or your covered dependent do not notify the Plan Administrator within this 60-day period, you may not elect or continue COBRA coverage.**

### *Other options*

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 (the 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/DP's plan), even if that plan generally does not accept late enrollees.

### *How to elect COBRA coverage*

✓ Each individual qualified beneficiary may separately decide whether to continue coverage under COBRA. This means you can enroll yourself without enrolling your covered spouse/DP and/or covered children and vice versa.

Within 14 calendar days after receiving notification of a qualifying event, the Plan Administrator or his designated COBRA Administrator will notify you of your right to continue coverage. Under the law, you have 60 days from the qualifying event or the date of the COBRA notice (whichever is later), to elect coverage. If you do not elect COBRA coverage within those 60 days, your coverage ends in accordance with plan provisions.

### *Cost of COBRA coverage*

You will be required to pay the entire cost of continuation coverage under COBRA. This includes employer and employee contributions — plus a 2% administrative fee. If you or your covered dependents' extension of COBRA coverage is due to disability, you must pay 150% of the full monthly cost for months 19 – 29.

Your COBRA enrollment materials will contain detailed information about possible methods of payment. You will have 45 calendar days from the day you sign the election form to submit the initial payment for COBRA coverage.

**If you do not make payments as required, you will lose all COBRA rights under the plan, and claims for expenses incurred after your coverage ends will not be paid by the plan.**

Once COBRA coverage is terminated, for non-payment or any other reason, it cannot be reinstated.

### *When COBRA coverage ends*

COBRA coverage ends on the earliest of the following dates:

- The date the Company ceases to provide any group health plan for its employees.
- The date full payment to the plan's COBRA Administrator is not made on a timely basis.
- The date coverage is obtained as an employee or dependent under another group health plan. However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.
- The date the covered person becomes eligible for Medicare benefits.
- If coverage was extended to 29 months due to disability, the date the disabled person is found by the Social Security Administration to be no longer disabled.
- The date group health plan coverage is terminated for any reason the plan would terminate coverage for a non-COBRA participant.
- The date the Company ceases to maintain any group health plan. If a new plan is implemented, COBRA coverage must be continued.
- The end of the applicable 18-, 19- or 36-month period.

**Notification required**

It is your responsibility to inform the COBRA Administrator when a qualified beneficiary becomes covered under another group health plan, becomes eligible for Medicare or is no longer disabled. Failure to do so will result in non-payment of claims after the event and will require reimbursement of any improperly paid claims.

✓ For more information about COBRA, call the COBRA Administrator.

For more information about the Marketplace, visit www.Healthcare.gov.

## Continuing coverage under USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health care coverage and re-employment in regard to an employee's military leave of absence. This includes the right to elect to continue your existing Company-sponsored health care coverage (medical, prescription drug, EAP, dental and vision) for you and your dependents for up to 24 months while in the military, if that coverage would otherwise end.

If your military leave is less than 31 days, the Company will continue to pay its portion of the cost of benefits, and you may continue your coverage as long as you pay your required contributions.

For leaves of 31 days or more, you may continue health care coverage for yourself and your covered dependents for up to 24 months by paying the entire cost of coverage. This includes employer and employee contributions — plus a 2% administrative fee. You may also continue your Health Care FSA participation until the end of the calendar year by making after-tax contributions to the plan, plus a 2% administrative fee. Your continuation coverage enrollment materials will contain detailed information about possible methods of payment.

Your USERRA continuation coverage will end on the earliest of these dates:

- 24 months from your last day of active employment.
- The day after you fail to return to work within the time required under USERRA following the completion of your service in the uniformed services.
- The date the Company ceases to provide any group health plan for its employees.
- The date you fail to provide payment for coverage on a timely basis.
- The date a qualified beneficiary engages in conduct that would justify the plan terminating the coverage — including continuation coverage — of a similarly situated participant (such as undesirable conduct, including court martial or dishonorable discharge).

**Important note**

COBRA and USERRA continuation of medical, prescription drug, EAP, dental and/or vision coverage are concurrent for the first 18 months. However, unlike COBRA, your dependents do *not* have a separate election right under USERRA. Your dependents can only be covered under USERRA continuation coverage if you are also enrolled.

You must apply for employment or return to employment within the period required under USERRA for benefit reinstatement. If you cancelled your plan coverage while on military leave of absence, it will be reinstated after your return to work. If you return to work from a military leave of absence during the same calendar year, you will be re-enrolled automatically in the same coverage options that you had before the leave began. If you return to work from a military leave of absence in a different year, you can make new coverage elections.

If your coverage ends during your leave of absence because you do not elect USERRA continuation coverage or an available conversion plan at the expiration of USERRA and you are re-employed by your current employer, coverage for you and your dependents may be reinstated if:

- You gave your employer advance written or verbal notice (if possible) of your military service leave; and
- The duration of all military leaves while you are employed with your current employer does not exceed five years.

You and your dependents will be subject to only the balance of a pre-existing condition limitation or waiting period that was not yet satisfied before the leave began. However, if an injury or sickness occurs or is aggravated during the military leave, full plan limitations will apply. Any 63-day "break in coverage" rule regarding credit for time accrued toward a pre-existing condition limitation waiting period will be waived.

If your coverage under this plan terminates as a result of your eligibility for military medical coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

## Claims and appeals procedures

See "How to file a claim" in each of the separate benefit chapters for information on how to file a claim for plan benefits. This section informs you what to do if your claim is denied or if you have been refused a benefit or reimbursement by a plan.

If, as a participant or beneficiary, you believe that you are entitled to benefits or rights under a plan which has not been provided, you should file a written claim to the Claims Administrator. The claim should be addressed to the Claims Administrator for the applicable plan, as indicated in the chart below.

| Benefits | Claims Administrator |
|---|---|
| **Employee Assistance Program (EAP)** | ComPsych GuidanceResources Worldwide<br>1-866-207-5157 (U.S.)<br>1-866-641-3847 (Canada)<br>https://www.guidanceresources.com/groWeb/login/login.xhtml<br>Web ID: **APTIM** |
| **Medical and Prescription Drugs** | Elected Carrier<br>See the *Contacts* section starting on page R-1 |
| **Dental** | Elected Carrier<br>See the *Contacts* section starting on page R-1 |
| **Health Savings Account (HSA)** | Bank of America<br>1-866-791-0250 |
| **Flexible spending accounts (FSAs)** | Alight Smart-Choice Accounts™<br>http://digital.alight.com/aptim |
| **Vision** | Elected Carrier<br>See the *Contacts* section starting on page R-1 |
| ▪ **Life and AD&D insurance**<br>▪ **Long-term disability (LTD)**<br>▪ **Short-term disability (STD)** | Prudential<br>1-800-842-1718<br>ABS Phone: 1-877-367-7781<br>www.prudential.com/mybenefits |
| **Travel accident insurance** | AIG Claims Department<br>P.O. Box 25987<br>Shawnee Mission, KS 66225 |
| **Salary continuation** | APTIM<br>leaves@aptim.com |

If a benefit is denied, the claims and appeals procedures under each benefit plan varies. For details on each plan, see the following pages:

- Life, AD&D, travel accident and disability benefits: pages R-16 – R-18.
- Medical, dental, prescription drug, vision, and health care FSA benefits: page R-19.

**This is a summary only!** If a claim or appeal is denied, the Claims Administrator will give you more detailed information.

## Claims and appeals for life, AD&D, travel accident and disability benefits

The Claims Administrator must let you know its decision on your claim within a specific time period after receiving the claim as shown below.

| For these benefit claims … | The initial decision will be made … |
|---|---|
| ▪ **Life insurance**<br>▪ **AD&D insurance**<br>▪ **Travel accident insurance** | Within 90 days. |
| ▪ **Long-term disability (LTD)**<br>▪ **Short-term disability (STD)** | Within 45 days. |

The Claims Administrator will send you a written decision on your claim. The Claims Administrator may need additional time or information to decide the claim. If this happens, the Claims Administrator will notify you in writing (within the initial decision timeframe, as outlined in the chart above). The Claims Administrator will also tell you why the extension is needed and what else it may need from you. The Claims Administrator may request an extension of time as shown below.

| For these benefit claims … | To make a decision on your claim, the Claims Administrator may require an extension of … |
|---|---|
| ▪ **Life insurance**<br>▪ **AD&D insurance**<br>▪ **Travel accident insurance** | An additional 90 days. |
| ▪ **Long-term disability (LTD)**<br>▪ **Short-term disability (STD)** | An additional 30 days.<br>If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the plan, a decision cannot be made within the extension period, the period for making the determination may be extended for up to an additional 30 days. In this case, the Claims Administrator must notify you, prior to the expiration of the first 30-day period, of the date it expects to render a decision and specifically explain:<br>▪ The standards on which entitlement to a benefit is based;<br>▪ The unresolved issues that prevent a decision on the claim; and<br>▪ The additional information needed to resolve those issues.<br>You will have at least 45 days to provide any additional required information. |

### *If a claim is denied*

If any part of your claim is denied, the Claims Administrator will provide a written notice that includes:

- The reasons for the denial;
- The pertinent plan provisions on which the denial is based;
- Any materials or information needed to reconsider the claim and an explanation of why the additional information is necessary; and
- The steps you must take if you wish to appeal the denial, including a statement that you may bring a civil action under ERISA.

In addition to the above information, if the claim relates to disability benefits, the following information will also be included with the notice:

- *If an internal rule, guideline, protocol or other similar criterion was used to make the adverse determination,* the notice will either include that rule, guideline, protocol or other similar criterion, or a statement it was relied upon and will be provided free of charge upon request; or
- *If the adverse benefit determination is based on a medical necessity, experimental treatment or similar exclusion or limit,* the notice will include either an explanation of the scientific or clinical judgment for the determination (applying the terms of the plan to your medical circumstances), or a statement that such explanation will be provided free of charge upon request.

If you wish to have a denied claim reviewed, you should follow the appeals procedures detailed below and on the next page.

**Important information about appeals**

In preparing your appeal, you are entitled to review any pertinent plan documents. You may have a representative act on your behalf.

If you do not fully follow these procedures for the review of your denied claim, you could lose your legal right to later have your claim reviewed in a court of law.

### *How to file an appeal*

Appeals must be filed within very specific timeframes. If you miss the deadlines shown below, you CANNOT appeal your denied claim. The "time to appeal" starts when you receive a written notification of your denied claim.

| For these benefit claims … | You must file a written appeal within … | And the Claims Administrator will respond to your appeal within … |
|---|---|---|
| ▪ **Life insurance**<br>▪ **AD&D insurance**<br>▪ **Travel accident insurance** | 60 days. | 60 days. |
| ▪ **Long-term disability (LTD)**<br>▪ **Short-term disability (STD)** | 180 days. | 45 days. |

The Claims Administrator will send you a written decision on your appealed claim. The Claims Administrator may need additional time or information to decide the appealed claim. If this happens, the Claims Administrator will notify you in writing (within the appeal decision timeframe, as outlined in the chart on page R-17). The Claims Administrator may request an extension of time as shown below.

| For these benefit claims … | To make a decision on your appealed claim, the Claims Administrator may require an extension of … |
|---|---|
| ▪ **Life insurance**<br>▪ **AD&D insurance**<br>▪ **Travel accident insurance** | An additional 60 days. |
| ▪ **Long-term disability (LTD)**<br>▪ **Short-term disability (STD)** | An additional 45 days. |

Your appeal must be in writing to the appropriate Claims Administrator listed on pages R-3 – R-4. Your initial claim denial will indicate the information that must be included with your appeal — or you can contact the Claims Administrator for specific information. The Claims Administrator's review will take into account everything you submit without regard to whether the information was submitted or considered in connection with your original claim.

If any part of your appeal is denied, the Claims Administrator will provide a written notice that includes:

- The reasons for the denial;
- The pertinent plan provisions on which the denial is based; and
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to — and copies of — all documents, records and other information relevant to your benefit claim or appeal.

**The decision of the Claims Administrator on all appeals is final.** However, if you have gone through the appeals process and still believe you are entitled to a plan benefit, you also have the right to bring a civil action under Section 502(a) of ERISA. In most instances, you may not initiate a legal action against the Claims Administrator until you have completed the appeals process. In addition, you or the plan may have other voluntary alternative dispute resolution options, such as mediation. You can find out what may be available by contacting your local U.S. Department of Labor office. You may also contact the Plan Administrator.

*A special note about disability appeals*

In considering the appeal of a disability benefit, the Claims Administrator will:

- Provide for a review that does not rely on the original denial and that is conducted by an appropriate named fiduciary of the plan. The named fiduciary of the plan will not be either the individual who made the original denial that is the subject of the appeal, nor a subordinate of that individual;
- Provide that, in deciding an appeal of any denial that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your denial, without regard to whether the advice was relied upon in making the original denial; and
- Provide that the health care professional who is consulted as described above will not be either an individual who was consulted in connection with the original denial that is the subject of the appeal, nor a subordinate of that individual.

## Claims and appeals for medical, dental, prescription drug, vision, and health care FSA benefits

To initiate a claim or an appeal of a denied claim, contact the appropriate claims administrator of your elected carrier. See the *Contacts* section starting on page R-1 for information.

### *Legal action*

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. In most instances, you may not initiate legal action against the Claims Administrator until you have completed the appeals process. Legal action must be initiated within **three years** after the submission of a claim. In addition, you or your plan may have other voluntary alternative dispute resolution options, such as mediation. You can find out what may be available by contacting your local U.S. Department of Labor office and your state insurance regulatory agency. You may also contact the Plan Administrator.

# Legal notices

**Important note**

You can find a copy of all of the legal notices required under ERISA, the Health Insurance Portability and Accountability Act (HIPAA), Medicare, Medicaid and the Children's Health Insurance Program (CHIP) and others on the APTIM Benefits Marketplace website, http://digital.alight.com/aptim.

## Newborns' and Mothers' Health Protection Act

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

If you would like more information about maternity benefits, please contact the Plan Administrator.

# Contacts

When you have a question about eligibility or benefits, you should contact the appropriate service center or benefit administrator for the particular plan.

## Who do I call?

There are many resources that can help when you have a question — and the nature of your issue can help determine the best place to start.

### Contact the APTIM Benefits Marketplace online or via the telephone regarding …

- Eligibility for coverage.
- Your benefit options.
- Benefit premiums and/or employee contributions.
- The new hire or annual benefits open enrollment process.
- Questions about the dependent eligibility audit process.
- Questions about family status changes that may affect your benefits (for example, marriage, birth, adoption, or divorce). You should make your family status changes online through the APTIM Benefits Marketplace website at http://digital.alight.com/aptim or by calling 1-833-476-2342, Monday through Friday from 8 a.m. to 5 p.m. CT, within 31 days of a qualifying life event.
- Employment status changes that may affect your benefits (for example, an increase or decrease in work hours that changes your status from full-time to part-time or vice versa).
- Updates to your life insurance and/or AD&D beneficiary designations.

### Contact your insurance carrier regarding …

- Help understanding your benefit plan and how it works.
- Resolving health insurance claims or billing issues (medical, prescription drug, dental, vision, HSA, and Health Care FSA).
- Assistance with finding the right doctors and hospitals.
- Help scheduling appointments, especially with hard-to-reach specialists.
- Securing second opinions.
- Obtaining ID cards.
- Information about your covered benefits.
- Locating in-network providers, facilities, hospitals, and pharmacies.
- Questions or disputes about your Explanation of Benefits (EOB).
- How to file a claim.
- The status of a claim or appeal.

### Contact your local Human Resources department regarding …

- Taking a leave of absence.
- Filing a workers' compensation claim.
- Changing your address or phone number on file with the Company.
- Transferring to another location within the Company.
- Terminating employment.

✓ The contact information for the APTIM Benefits Marketplace and the benefits administrators/ insurance companies is on the next page.

**Using the APTIM Benefits Marketplace website**

From work or home, you can access the APTIM Benefits Marketplace website at http://digital.alight.com/aptim.

If you are logging in for the first time, click "New User?" to create an account. If you are having issues logging in, click "Forgot User ID or Password?"

If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

## Phone numbers and websites

The following chart includes the phone numbers, websites and/or Mobile App information for the APTIM Benefits Marketplace and the benefits administrators and insurance companies.

| Benefit plan(s) | Administrator/contact | Phone number(s) | Website and/or Mobile App |
|---|---|---|---|
| **All APTIM Health & Welfare Benefits** | APTIM Benefits Marketplace | 1-833-476-2342<br>Monday through Friday from 8 a.m. to 5 p.m. CT | http://digital.alight.com/aptim |
| **General HR-related Questions** | HR Service Desk | 1-833-278-4643 and select option 3 for HR<br>Monday through Thursday from 7:30 a.m. to 5 p.m. and Fridays from 7:30 to noon CT | HRQuestions@aptim.com |
| **Leaves of Absence** | APTIM | | leaves@aptim.com |
| **Medical** | Aetna | 1-855-496-6289 | https://www.aetna.com |
| | BCBS of Hawaii (HMSA) | 1-800-651-4672 or 1-808-948-6121 | https://members.hmsa.com |
| | BCBS of Texas | 1-877-217-7986 | https://www.bcbstx.com/member/register |
| | Cigna | 1-855-694-9638 | https://my.cigna.com |
| | Cigna – CA | 1-855-694-9638 | https://my.cigna.com |
| | Dean/Prevea360 | 1-877-232-9375 | http://aon.deanhealthplan.com |
| | Geisinger | 1-844-390-8332 | https://www.geisinger.org/member-portal |
| | Health Net | 1-888-926-1692 | https://www.healthnet.com/myaon |
| | Kaiser – CA | 1-877-580-6125 before you are a member; 1-800-464-4000 once you are a member | http://www.kp.org |
| | Kaiser – CO | 1-877-580-6125 before you are a member; 1-303-338-3800 once you are a member | http://www.kp.org |
| | Kaiser – GA | 1-877-580-6125 before you are a member; 1-888-865-5813 or 404-261-2590 once you are a member | http://www.kp.org |
| | Kaiser – HI | 1-877-580-6125 before you are a member; 1-808-432-5955 once you are a member | http://www.kp.org |
| | Kaiser – MAS | 1-877-580-6125 before you are a member; 1-800-777-7902 once you are a member | http://www.kp.org |
| | Kaiser – NW | 1-877-580-6125 before you are a member; 1-800-813-2000 once you are a member | http://www.kp.org |
| | Kaiser – WA | 1-855-407-0900 | https://wa-member.kaiserpermanente.org |
| | Medical Mutual | 1-800-677-8028 before you are a member; 1-800-541-2770 once you are a member | https://member.medmutual.com |
| | Priority Health | 1-833-207-3211 | https://member.priorityhealth.com/login |
| | United | 1-888-297-0878 | http://myuhc.com |
| | UPMC | 1-844-252-0690 | https://www.upmchealthplan.com/members |

*(continued)*

| Benefit plan(s) | Administrator/contact | Phone number(s) | Website and/or Mobile App |
|---|---|---|---|
| **Medical Benefits Abroad** | Cigna | 1-800-441-2668 | www.cignaenvoy.com |
| **Dental** | Aetna | 1-855-496-6289 | https://www.aetna.com |
| | Cigna | 1-855-694-9638 | https://my.cigna.com |
| | Delta Dental – CA | 1-800-503-4162 before you are a member; 1-800-471-7614 once you are a member | http://www.deltadentalins.com |
| | DeltaCare USA Platinum | 1-800-503-4162 before you are a member; 1-800-471-7614 once you are a member | http://www.deltadentalins.com |
| | MetLife | 1-888-309-5526 | https://www.metlife.com/mybenefits |
| | United | 1-888-571-5218 | https://www.myuhc.com |
| **Vision** | EyeMed | 1-844-739-9837 | https://www.eyemedvisioncare.com/member/public/login.emvc |
| | MetLife | 1-888-309-5526 | https://www.metlife.com/mybenefits |
| | United | 1-888-571-5218 | https://www.myuhcvision.com |
| | VSP | 1-877-478-7559 | https://www.vsp.com/signon.html |
| **Employee Assistance Program (EAP)** | ComPsych GuidanceResources Worldwide | 1-866-207-5157 (U.S.)<br>1-866-641-3847 (Canada) | https://www.guidanceresources.com/groWeb/login/login.xhtml<br>Web ID: APTIM |
| **TRICARE** | Selman | 1-800-638-2610 | www.selmantricareresource.com/aptim |
| **Health Savings Account (HSA)** | Bank of America | 1-866-791-0250 | https://myhealth.bankofamerica.com |
| **Flexible Spending Accounts (FSAs)** | Alight Smart-Choice Accounts™ | 1-833-476-2342 and follow the prompts | http://digital.alight.com/aptim or Alight Smart-Choice App |
| **Life Insurance and AD&D** | Prudential | 1-800-842-1718<br>ABS Phone: 1-877-367-7781 | www.prudential.com/mybenefits |
| **Travel Accident** | AIG | 1-877-244-6871 (within US)<br>1-715-346-0859 (Outside US) | aig.com/us/travelguardassistance<br>Policy Holder:<br>APTIM Holding Corp.<br>Policy Number:<br>GTP 00009155203 |
| **Commuter Benefits** | Alight Smart-Choice Accounts™ | 1-833-476-2342 and follow the prompts | digital.alight.com/aptim |
| **Salary Continuation Plan** *(salaried employees)* | APTIM | | leaves@aptim.com |
| **Short-Term Disability (STD) Claim Initiation** *(hourly/craft employees)* | Prudential | 1-800-842-1718<br>ABS Phone: 1-877-367-7781 | www.prudential.com/mybenefits |
| **STD Buy-Up Option** *(salaried employees)* | Prudential | 1-800-842-1718<br>ABS Phone: 1-877-367-7781 | www.prudential.com/mybenefits |
| **Long-Term Disability (LTD)** | Prudential | 1-800-842-1718<br>ABS Phone: 1-877-367-7781 | www.prudential.com/mybenefits |
| **LTD Buy-Up Option** *(salaried employees)* | Prudential | 1-800-842-1718<br>ABS Phone: 1-877-367-7781 | www.prudential.com/mybenefits |
| **Accident, Hospital Indemnity, Critical Illness Insurance** | Prudential | 1-844-455-1002<br>Monday through Friday from 7 a.m. to 7 p.m. CT | www.prudential.com/mybenefits |

*(continued)*

| Benefit plan(s) | Administrator/contact | Phone number(s) | Website and/or Mobile App |
|---|---|---|---|
| **Identity Theft Protection Plan** | Allstate Identity Protection | 1-800-789-2720 | |
| **APTIM 401(k)** | Aon PEP/Voya Financial | 1-833-AON-9PEP (1-833-266-9737) | aonpep.voya.com |
| **APTIM Employee Discount Program** | Working Advantage | | https://apt.savings.workingadvantage.com |
| **APTIM WW Program** | WW (Weight Watchers) | | www.weightwatchers.com/us/aptim |

# Glossary

If there is a discrepancy between this SPD and the plan documents, the plan documents will govern.

✓ Some of the terms have more than one definition, depending on the benefit plan to which they apply. Those terms are indicated by an asterisk. In the *Glossary* section, any reference to the "plan" is a reference to one or more of the benefit plans described in this SPD.

**Accident:** An unforeseen and unavoidable event resulting in an injury that is not due to any fault of the covered person, excluding any work-related injuries.

**Adverse benefit determination:** A denial, reduction or termination of — or a failure to provide or make payment (in whole or in part) for — a plan benefit, including a determination based on a participant's eligibility to participate in the plan.

**Annual base pay:** For life insurance, AD&D, and travel accident insurance, annual base pay is your annual base salary, not including any bonuses, commissions, overtime pay, or any other compensation.

**Annual benefits open enrollment:** The period each year during the fall when benefits-eligible employees can change benefit coverage elections, with the new coverage effective on January 1 of the following calendar year.

**Beneficiary:** The person(s) or entity(ies) you designate to receive specific benefits in the event of your death. The designation must be on file with the APTIM Benefits Marketplace at the time of death to be effective.

**Brand-name drugs:** Prescription drugs that are manufactured under a trademark or a registered trademark.

**Charges:** The actual billed charges for covered services under the plan, except when an in-network provider has contracted directly or indirectly with the Claims Administrator for a different amount.

**Claim:** A request you make for a plan benefit in accordance with the plan's established procedures for filing benefit claims.

**Claims Administrator:** The insurance company or other entity authorized by each of the benefit plans to process claims and administer benefits under the plan.

**COBRA:** The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. COBRA is a federal law that provides for continuation coverage for employees and covered dependents who, under certain circumstances, would otherwise lose their group health coverage.

**Coinsurance:** The percentage of covered expenses paid by you or the plan each year after you have met the deductible, if applicable.

**Company business:** For travel accident insurance, Company business includes all circumstances arising from or occurring while you are traveling on assignment by or at the direction of the Company, including relocation (which is an assignment to a new regular place of employment).

**Concurrent care claim:** When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must file a concurrent care claim at least 24 hours prior to the expiration of the approved period of time or number of treatments.

**Contribution:** The amount that you pay toward the cost of coverage to participate in a plan described in this SPD. For active employees receiving a paycheck, your contributions for coverage are deducted from your pay.

**Coordination of benefits:** If you or your eligible covered dependents have coverage under more than one medical or dental plan, the plan implements its "coordination of benefits" provision. In such cases, subject to applicable law, coordination of benefit rules determine which plan is primary — meaning which plan pays first and to what extent. With coordination of benefits, your elected carrier works with other insurance companies to make sure that you receive all of the health insurance coverage you are entitled to from all insurance plans.

**Copay (or copayment):** A cost-sharing arrangement where you or your covered dependent pays a fixed charge to a provider for a specific service at the time the service is provided.

**Cosmetic:** Services or supplies that alter, improve or enhance appearance.

**Covered accident:** For AD&D and travel accident insurance, an event not otherwise excluded by the insurance contract that results in a bodily injury or death for which the Claims Administrator determines that benefits are payable.

**Covered earnings:** Under the LTD Plan, your base pay rate in effect for the last complete payroll period before the start of your disability. It does not include bonuses, overtime pay, or any other extra compensation or income received from sources other than your employer.

**Covered expenses:** The items, services and supplies for which benefits may be paid under the plan.

**Creditable coverage:** A person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes:

- Health coverage issued on a group or individual basis.
- Medicare.
- Medicaid.
- Health care for members of the Uniformed Services.
- A program of the Indian Health Service.
- A state health benefits risk pool.
- The Federal Employees' Health Benefit Plan (FEHBP).
- A public health plan (any plan established by a state, the government of the United States or any subdivision of a state or of the government of the United States, or a foreign country).
- Any health benefit plan under Section 5(e) of the Peace Corps Act.
- A state Children's Health Insurance Program (CHIP).

**Creditable prescription drug coverage:** Prescription drug coverage that is, on average, at least as good as the Medicare standard prescription drug coverage. This determination of creditable coverage is defined by the Centers for Medicare and Medicaid Services (CMS) and is made by independent actuarial attestation.

**Custodial care:** Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care or nursing services to care for someone because of age or mental or physical condition. The services primarily help the person in daily living. Custodial care can also include medical services, given mainly to maintain the person's current state of health and not intended to greatly improve a medical condition. The care is provided while the patient cannot care for himself or herself. Custodial care includes, but is not limited to:

- Services related to watching or protecting a person.
- Services not required to be performed by trained or skilled medical or paramedical personnel.
- Services related to performing or assisting a person in performing any activities of daily living, such as:
  - Walking.
  - Grooming.
  - Bathing.
  - Dressing.
  - Getting in or out of bed.
  - Toileting.
  - Eating.
  - Preparing foods.
  - Taking medications that can usually be self-administered.

**Deductible:** The amount you are required to pay each plan year before certain benefits are payable by the plan. Once the deductible has been met, expenses are reimbursed based on the coinsurance percentage. The deductible counts towards your out-of-pocket maximum.

**Dentist:** A person practicing dentistry or oral surgery within the scope of his or her license. Also includes a physician operating within the scope of his or her license when performing dental services.

**Disability* (LTD Plan):** You are considered disabled under the Long-Term Disability (LTD) Plan if you are unable to work due to illness or accidental injury, you are under the appropriate care and treatment of a physician and are complying with the requirements of such treatment, and meet the following requirements:

- During the 180-day elimination period and for the next 24 months:
  - You cannot perform the material duties of your regular occupation with the Company; and
  - You are unable to earn more than 80% of your covered earnings from working in your regular occupation.
- After first 24 months of disability:
  - You cannot perform the material duties of any occupation for which you have the training, education, or experience; and
  - You are unable to earn 60% or more of your covered earnings from working in your regular occupation.

**Disability* (STD Plan):** You are considered disabled under the Short-Term Disability (STD) Plan if, as a result of injury or sickness:

- You cannot perform one or more of the essential duties of your job; and
- You are unable to earn 80% or more of your earnings from working in your regular occupation.

To be considered disabled and eligible for STD benefits:

- Your condition must require the regular care of a doctor.
- You must be able to provide proof of your continuing disability at reasonable intervals. If you cannot provide that proof, or if you refuse to be examined by a physician (designated and paid for by the Insurance Company), you will no longer be considered disabled.
- You are required to apply for all other income benefits for which you may be eligible, and provide a statement of those amounts if requested by the Insurance Company. If you do not apply for all other income benefits, the Insurance Company has the right to reduce your benefit by the estimated amount of any other income benefits for which you may be eligible.

**Domestic Partner (DP):** Domestic partner is a person of the same or opposite sex with whom you have an interpersonal relationship sharing a domestic life as if married; however, legally unmarried as marriage is unrecognized by law.

**Elimination period:** A period of continuous disability that must be satisfied before you will begin to receive disability benefit payments.

**Emergency care:** A medical emergency is defined as a serious accident or sudden illness with severe symptoms which often occur unexpectedly and require immediate attention or could reasonably be expected by a prudent layperson to result in a long-term medical problem, severe disability or loss of life. The presenting symptoms, as coded by the provider and recorded by the hospital on the claim form, or the final diagnosis, whichever reasonably indicates an emergency medical condition, will be the basis for the determination of whether care qualifies as emergency care.

**Entitled to Medicare:** An individual who:

- Is receiving Medicare benefits; or
- Would receive such benefits if he or she made application to the Social Security Administration.

**ERISA:** The Employee Retirement Income Security Act of 1974, as amended.

**Evidence of Insurability (EOI):** A medical questionnaire you need to complete and submit to an insurance company when you apply for certain amounts of optional life insurance or disability coverage. The Claims Administrator will use this information to determine your insurability under the applicable plan.

**Explanation of Benefits (EOB):** Provides information about how your claim was processed by the carrier. The EOB outlines what portion of the claim was paid by the Plan and what portion is your responsibility.

**Flexible Spending Account (FSA):** An FSA allows you to set aside a portion of your salary on a pre-tax basis to pay for qualified expenses, most commonly for healthcare expenses but often for dependent care or other qualified expenses. Money deducted from your pay into an FSA is not generally subject to payroll taxes, resulting in payroll tax savings.

**FMLA:** The Family and Medical Leave Act of 1993, as amended. FMLA generally requires that employers with 50 or more employees must allow eligible employees to take up to 12 weeks of unpaid, job-protected leave each year for births, adoptions, foster care placement, illnesses, and/or injuries.

**Formulary:** A continually updated list of prescription drugs covered by the plan, based on the latest research and evidence of safety and effectiveness.

**Foster child:** An individual under the age of 26 who is placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction, and who is your "eligible foster child" for purposes of Code section 152(f)(1)(A)(ii). Under the applicable state law, the maximum age for a foster child may be less than 26.

**Generic drugs:** Prescription drugs identified by their official chemical names rather than their advertised brand names. These drugs are made with the same active ingredients and are available in the same strength and dosage as the equivalent brand-name drugs. Generic drugs meet the same FDA standards for safety, strength and effectiveness as brand-name drugs.

**Health care provider:** A physician, practitioner, hospital, laboratory, nurse, specialized facility, or anyone who delivers medical or health-related care.

**Healthcare Reform:** Signed into law by President Obama on March 23, 2010, to expand healthcare coverage through a combination of cost controls, subsidies, and mandates.

**HIPAA:** The Health Insurance Portability and Accountability Act of 1996, as amended.

**Home health services:** Services for:

- Part-time nursing care rendered in the covered person's home by:
  - A registered nurse;
  - A licensed practical nurse;
  - A licensed public health nurse; or
  - A licensed vocational nurse under the supervision of a registered nurse.
- Physical, occupational, or speech therapy provided in the covered person's home.
- Use of medical equipment provided on an outpatient basis by a home health care agency or a hospital or other facility if arranged for by the home health care agency.
- Intermittent visits of two hours or less by other health care professionals.

This term does not include a service provided by a member of the covered person's immediate family or a person who normally lives in the covered person's home, a service which is not needed for the treatment of an injury or sickness or a service otherwise excluded by the plan.

**Hospice:** A coordinated plan of home and/or inpatient care which treats the terminally ill patient and family as a unit. The plan provides care to meet the special needs of the family unit during the final stages of a terminal illness and during bereavement. Care is provided by a team which:

- Is made up of trained medical personnel, homemakers, and counselors;
- Acts under an independent hospice administration; and
- Assists the family in coping with physical, psychological and economic stresses.

The hospice administration must be approved by the Claims Administrator as meeting established standards, including any legal licensing requirements of the state or locality in which it operates.

**Hospital:** A legally constituted and operated institution that has organized facilities on the premises (which include those for diagnosis and major surgery) to care for and treat sick and injured persons. There must be supervision by a staff of doctors with a registered nurse (RN) on duty at all times. This term does not include any institution, or part of one, used mainly for any of the following:

- Rest care.
- Nursing care.
- Convalescent care.
- Care of the aged.
- Care of the chronically ill.
- Custodial care.
- Education.

**Hospital confinement:** A person will be considered confined in a hospital if he or she is a registered bed patient in a hospital upon the recommendation of a physician or is partially confined for treatment of:

- Mental health;
- Substance abuse; or
- Other related illness.

**Imputed income:** The IRS requires you to be taxed on the value of employer-provided basic life insurance coverage over $50,000 and on the premiums for employer-paid long-term disability (LTD) coverage for salaried employees. The taxable value of this coverage is called "imputed income." Even though you do not receive cash, you are taxed as if you received cash in an amount equal to the value of this coverage. Imputed income is added to your total compensation reported to the IRS, appears on your W-2 statement and is taxable at your regular income tax rate on a per-pay-period basis.

**Independent review organization:** A group of persons who are not employed by the Company or any of its affiliates or by your elected carrier, or any of its affiliates. The independent review organization is responsible for reviewing a final appeal regarding a claim's medical necessity or clinical appropriateness.

**Injury* (AD&D Plan):** Any bodily harm that results directly and independently of all other causes from a covered accident.

**Injury* (Medical Plan):** An accidental bodily injury that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.

The act or event must be definite as to time and place.

**In-network benefits:** The higher level of benefits that you receive when you obtain services from participating in-network providers.

**In-Network Providers/Services:** In-network providers are physicians, hospitals, pharmacies, or other healthcare providers that are contracted with an insurance company. In-network providers do not balance bill for covered services. In other words, they do not bill you for the difference between what they choose to reimburse for a service and what the provider chooses to charge. In-network providers accept the amount paid by the Plan (plus any member copay and/or coinsurance) as stated in their contracts.

**Inpatient rehabilitation institution:** An institution (other than a hospital) established to care for and treat those who need inpatient medical care due to alcoholism or narcotism. The institution must:

- Have permanent facilities on the premises for inpatient medical care.
- Be licensed, registered or approved by the appropriate authority of the jurisdiction in which it is located or be accredited by the American Hospital Association.
- Keep daily medical records on all patients.

The term does not include an institution, or part of one, used mainly for rest care, nursing care, care of the aged, or custodial care.

**Maintenance medication:** Prescription drugs taken on a regular or longer-term basis. Examples include medications for high blood pressure, high cholesterol, arthritis, heart conditions, and diabetes.

**Medically necessary/medical necessity* (Medical Plan):** Medically necessary covered services and supplies are those determined by each individual carrier to be:

- Required to diagnose or treat an illness, injury, disease or its symptoms;
- In accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site, and duration;
- Not primarily for the convenience of the patient, physician, or other health care provider; and
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Where applicable, an individual carrier's medical director may compare the cost-effectiveness of alternative services, setting or supplies when determining least intensive setting.

**Medically necessary/medical necessity* (Prescription drug):** The determination of medical necessity is made by each individual carrier and is for pre-service claim denials that were upheld in the first appeal. Care is considered medically necessary if:

- It is accepted by the health care profession in the United States as appropriate and effective for the condition being treated.
- It is based on recognized standards of the health care specialty involved.
- It represents the most appropriate level of care depending on the seriousness of the condition being treated, with respect to the frequency and duration of services and the place where services are performed.

**Medicare:** Parts A, B, C, and D of the insurance program established by Title XVIII of the Federal Social Security Act of 1965, as amended or revised from time to time. A person who is eligible for coverage under Medicare will be deemed to have all the coverage for which he or she is eligible.

**Network:** A large group of health care providers (or pharmacies) in a specified geographical area who have contracted with an insurance company to provide services under a specified quality management and negotiated fee arrangement.

**Network provider:** A health care provider, hospital, or facility in the United States that the Claims Administrator has designated as part of its provider network for the service or supply being provided. Also known as a "preferred provider."

**Non-occupational illness or injury:** An illness or injury that does not arise out of (or in the course of) any work for pay or profit, or result in any way from an illness or injury that does.

**Non-preferred brand drugs:** Medications that are not clinically superior to preferred brand alternatives and are more expensive for you and the Company. Generally, each non-preferred brand drug will have at least one generic or preferred brand alternative available at a lower cost.

These brand-name drugs are typically covered under the prescription drug benefit, but will have a higher cost, due to there being a clinically appropriate generic or preferred substitute for that drug.

**Orthodontia/orthodontic treatment:** Any medical or dental service or supply furnished to prevent, diagnose, or correct a misalignment of the teeth, bite, jaws, or jaw joint relationship.

**Other health insurance coverage:** The term, as used in connection with the special enrollment rights, means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical policy or certificate, hospital or medical plan contract, or health maintenance organization contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage and individual health coverage.

Certain types of coverage are not considered other health insurance coverage, such as:

- Coverage only for accident, or disability income insurance.
- Coverage issued as a supplement to liability insurance.
- Liability insurance.
- Workers' Compensation or similar insurance.
- Credit-only insurance.
- Coverage for on-site medical clinics.
- Part A, Part B, or Part D of Medicare.
- Medicaid, a State child health plan or the Children's Health Insurance Program.
- Medical and dental care for members and former members of the armed services.
- Medical care program of Indian Health Services or of a Tribal organization.
- Federal Employee Health Benefit Program.
- Peace Corps health plan.
- Public health plan (defined to be a plan of a state, county, or other political subdivision).
- Health coverage provided by foreign governments (e.g., Canadian health care system).

**Out-of-network benefits:** The (generally) lower level of benefits that you receive when you obtain health care services from providers not participating in the applicable network.

**Out-of-Network Providers/Services:** Out-of-network providers are physicians, hospitals, pharmacies, or other healthcare providers that are not contracted with an insurance company and may balance bill the member for covered services. If you choose to use an out-of-network doctor, services will not be provided at a discounted rate.

**Out-of-pocket maximum:** Under the Medical Plan and prescription drug benefit, the maximum amount you pay out-of-pocket for covered expenses in a plan year. Once this maximum is met, the Medical Plan or prescription drug benefit pays 100% of most covered expenses, up to the maximum reimbursable charge (MRC), if applicable, for the rest of the plan year.

**Outpatient:** A covered person will be considered an outpatient if he or she is treated at:

- A hospital (other than as an inpatient);
- A physician's office, laboratory, or X-ray facility; or
- An ambulatory surgical facility and the stay is less than 24 consecutive hours.

**Over-the-counter (OTC) medications:** Medications normally available without a prescription. With respect to the Health Care Flexible Spending Account and the Health Savings Account, a prescription is required for reimbursement of OTC medications. You may be required to submit a prescription or other documentation to substantiate your claim for reimbursement of an OTC medication.

**Pharmacy:** An establishment where prescription drugs are legally dispensed. This may be a retail pharmacy, mail order pharmacy, or Specialty Pharmacy.

**Physician:** A member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices; and
- Provides medical services that are within the scope of his or her license or certificate.

**Placed for adoption, placement for adoption:** A child (must be available for adoption and under the age of 18) has been placed for adoption with the covered employee in his or her home, whether or not the adoption has become final, as of the date of either (i) an order by a court of competent jurisdiction in the United States is issued placing the child in the home of the covered employee for the purpose of legally adopting the child and imposes a legal obligation on the covered employee for partial or total support of the child, or (ii) a legally binding contract between the covered employee and an authorized placement agency has been signed by both parties that is enforceable in a court of competent jurisdiction (also known as a "placement contract"), which places the child in the home of the covered employee for the purpose of legally adopting the child and imparts an obligation on the covered employee for partial or total support of the child.

**Plan year:** The calendar year (January 1 – December 31).

**Post-service claim:** A claim for a plan benefit that is rendered after services are provided and was not required to be pre-approved before the service was received in order to get the maximum plan benefit.

**Pre-authorization:** Under the Medical Plans, the process by which each individual carrier determines if certain outpatient services are medically necessary and appropriate.

**Pre-certification:** Under the Medical Plans, the process by which each individual carrier determines if an inpatient hospitalization is medically necessary and appropriate.

**Predetermination of benefits:** With respect to dental benefits, a voluntary review of a dentist's proposed treatment plan that can aid in estimating benefits that are payable by the plan before treatment begins.

**Preferred brand drugs:** Brand-name drugs that are on the formulary. The formulary includes clinically appropriate brand-name drugs that represent the prescription therapies believed to be a necessary part of a quality treatment program. Generally, preferred brand drugs cost more than generic drugs but less than non-preferred brand drugs.

**Pretreatment estimate:** Under the Medical Plan, a voluntary review of benefits that helps you plan your out-of-pocket expenses by advising you in advance if an out-of-network treatment or procedure will be covered or if the proposed fee is more than the maximum reimbursable charge.

**Preventive medical care:** Services that contribute to the prevention of a condition or disease. Examples of preventive care include physical exams, well-woman exams, well-child exams, routine immunizations and routine oral exams.

**Preventive prescription drugs:** Prescription drug medications that help avoid or prevent reoccurrence of an illness or condition. Medications within a category may change periodically. Each individual carrier sets preventive prescription drug medications clinical dispensing guidelines. Certain preventive prescription drugs may also be considered a maintenance medication and, in addition, be subject to those plan provisions.

**Primary coverage:** Under the coordination of benefits provision, the medical or dental insurance that is most responsible for paying your claims. Primary coverage pays benefits first, up to the allowable maximums, before any secondary or tertiary coverage.

**QMCSO:** A qualified medical child support order that creates or recognizes the right of a dependent child to receive medical coverage under a specific plan.

**Relocation:** An assignment to a new regular place of employment.

**Secondary or tertiary coverage:** Under the coordination of benefits provision, the medical or dental insurance that pays your health care claims after your primary coverage is exhausted.

**Service area:** Under the Medical Plans, the geographic area where a network of doctors is located.

**Specialist:** A physician who practices in any generally accepted medical or surgical sub-specialty.

**Specialty/biotech drugs:** Drugs prescribed for rare conditions or applications that are typically high-cost injectable, infused, oral, or inhaled drugs.

**Substance abuse:** A psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of substance abuse.

**Urgent care:** Medical treatment for conditions that require prompt medical attention, but are not life-threatening emergencies.

**USERRA:** The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

**WHCRA:** The Women's Health and Cancer Rights Act of 1998, as amended.

*For terms specific to individual carriers, review specific plan Summary Plan Description. See "Summary of benefits and coverage" on page B-6 for* Medical and Prescription Drug, *D-3 for* Dental, *and E-3 for* Vision *for carrier links.*