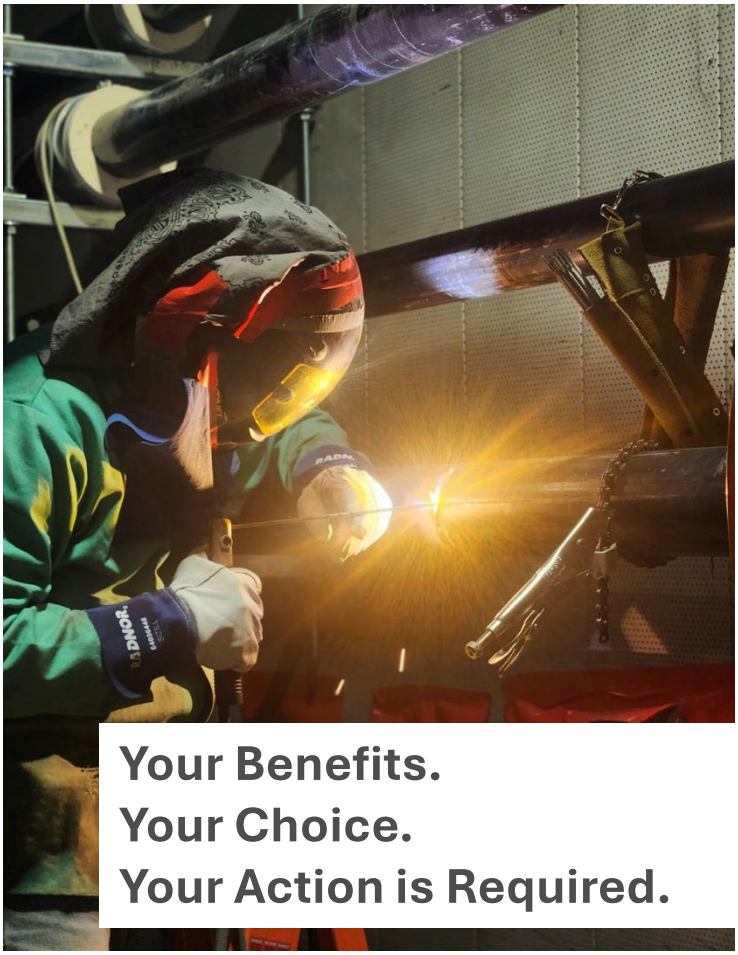


Your Benefits.
Your Choice.
Your Action is Required.

2026 BENEFITS
EXPATRIATES ONLY

Tutor Perini
CORPORATION

Dear Team Member,

Welcome to Tutor Perini!

As a valued new member of our team, you are eligible to participate in the Tutor Perini Employee Benefit Plans **AFTER 30 DAYS OF CONTINUOUS SERVICE**, provided you **ENROLL WITHIN 30 DAYS OF YOUR DATE OF HIRE**.

To assist you in making your benefit decisions, the following materials have been enclosed:

- New Hire Frequently Asked Questions (FAQ)
- Workday Enrollment Flyer: Provides instructions on how to access the enrollment website.

IMPORTANT

ENROLLMENT

You must complete your enrollment within 30 days of your date of hire. You may enroll online at **Workday**. Once you have completed the enrollment process, the benefit coverage(s) will begin as outlined in this Employee Benefit Brochure and in the applicable Summary Plan Description (SPD) provided your enrollment is completed correctly within the first 30 days of your date of hire.

RESOURCES AND INFORMATION

Benefit Advocates are available at 800-489-1390 Monday through Friday, from 5:00 a.m. to 5:00 p.m. Pacific Standard Time (PST) to help answer questions about your benefits. You may also access more information about the Tutor Perini Benefit Plans online at TutorPerini.MyBenefitsLibrary.com or contact your Human Resources Representative.

REGISTRATION

You will enroll online through **Workday** via Single Sign On (SSO) by entering your username and password and then complete a multi-factor authentication (MFA) step. If you have any questions or need assistance with logging in, please reach out to your IT or HR Representative.

Wishing you and your family the best of health!

Gino Cesario – SVP & Chief Human Resources Officer

CONTENTS

MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.

TAKE A CLOSER LOOK	4
GETTING STARTED	5
HOW TO ENROLL	6
IMPORTANT ENROLLMENT COMMUNICATIONS	7
WHO'S ELIGIBLE FOR BENEFITS?	8
ADDITIONAL ELIGIBILITY REQUIREMENTS	9
TOBACCO POLICY	10
CHANGING YOUR BENEFITS	11
MEDICAL	13
MEDICAL WITH VISION PLAN	16
BENEFIT COSTS	17
DENTAL	18
ENGAGE	20
LIFE & DISABILITY	26
ADDITIONAL BENEFITS	33
IMPORTANT PLAN INFORMATION	37

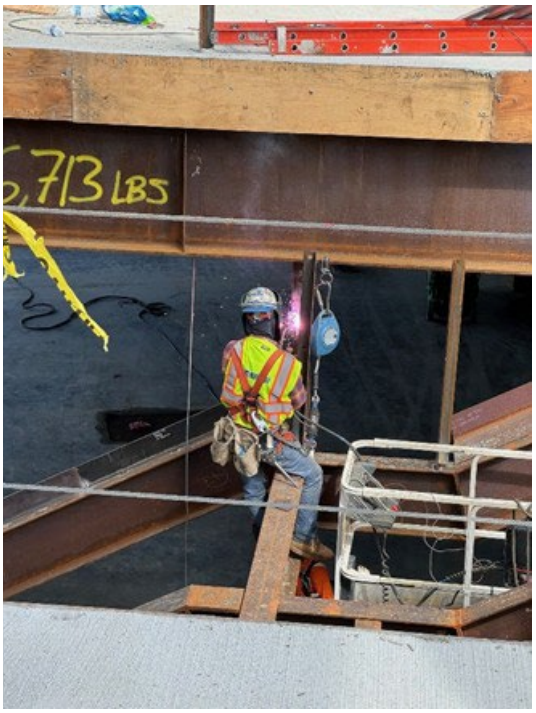
TAKE A CLOSER LOOK

This summary of benefits is being provided to give you an overview of the 2026 Tutor Perini benefit plans. Please review this material carefully and use the contact guide at the back of this summary to direct any of your questions about a particular benefit or situation.

DISCLAIMER: The information in this brochure is a general overview of the benefits offered under the Tutor Perini benefits plans. This brochure may not include all relevant limitations and conditions. Specific details and limitations are provided in the Plan documents, which may include a Summary Plan Description (SPD), Evidence of Coverage (EOC), and/or insurance policies. The plan documents contain the relevant plan provisions. If the information in this brochure differs from the plan documents, the plan documents will prevail. For more information, please contact Human Resources.

GETTING STARTED

2026 BENEFITS
JANUARY 1, 2026
through
DECEMBER 31, 2026



Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, Tutor Perini supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

ENROLLING FOR BENEFITS

HAVE QUESTIONS?

For additional information on your 2026 benefits, visit TutorPerini.MyBenefitsLibrary.com

Workday

All benefit elections will be completed in **Workday**. Log in to Workday and follow the instructions below to make your elections.

Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

Getting started

- LOG IN to **WORKDAY**
- SELECT **"Workday Login via SSO"** and enter your username and password.
- NAVIGATE to your Workday Inbox and click on the invitation to begin your Enrollment.
- ADD your personal and dependent information.
- SELECT your benefit plans for the coming year.
- REVIEW your choices and costs before finalizing.
- PRINT you Election Summary for your records.

Important Enrollment Communications

CONFIRMATION WORKSHEET

After you elect your benefits, it is important that you print a Confirmation Worksheet to review and ensure accuracy in your election(s). There will not be a Confirmation Worksheet mailed to your home, so you must print one, review it, and go back online if you need to make any changes.

Note: If you have updated your Tobacco status, it can take the system up to 24 hours to process. Please print an updated confirmation statement 24 hours after completing your election to show proper contributions.

The elections showing in the system at the close of the 2026 Open Enrollment period will remain in effect throughout 2026 unless you have a Qualified Life Event (QLE).

WHO'S ELIGIBLE FOR BENEFITS?

Dependent Verification

Any time a new dependent is added, dependent eligibility verification will be required. An initial verification email will be generated and sent from Workday. The initial verification email will outline eligibility documentation requirements, which must be submitted.

Eligibility and enrollment information will be placed in a pending status until required documentation is received. Required documentation should be submitted through Workday utilizing the document upload feature.

Employees

You are eligible to participate in the TPC Benefit Plans if you are a full-time employee working 30 or more hours per week. You may also enroll your eligible dependents.

Eligible dependents

- Legally married spouse (same or opposite sex)
- Domestic Partner (DP) (same or opposite sex)
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).
- For additional information, please refer to the benefit booklets for each benefit.

Domestic Partners

Same or opposite gender domestic partners (DP) will be eligible for benefits coverage if he/she is not a Tutor Perini employee who is eligible for Tutor Perini medical or dental benefits.

- A Common Law Spouse is treated as a domestic partner and is eligible for the same benefits as a spouse.
- Live together sharing a common domestic life for 12 months or greater, but neither are joined by marriage or a civil union.

The IRS treats the value of domestic partner and child(ren) of domestic partner coverage as taxable income which results in additional income tax withholding, called Imputed Income. This Imputed Income will be reported as "other compensation" on your W-2 form. Contributions for a domestic partner and/or child(ren) of a domestic partner are deducted on a post-tax basis.

ADDITIONAL ELIGIBILITY REQUIREMENTS

ACTIVELY AT WORK

You must actively be at work in order to elect Supplemental Life Insurance, Short Term Disability, and/or Long-Term Disability.

Coverage for dependents added due to a Federal Qualifying Life Event (QLE) become effective the first of the month following the date of the QLE provided the QLE is reported within 31 days.

- Newborn child(ren) must be added to the Plan within 31 days of birth and will be effective beginning their date of birth.

WHEN DOES COVERAGE END?

Generally, your health insurance and your voluntary insurance coverage will end:

- For medical, dental and vision – if your employment ends between the 1st and the 15th, coverage ends on the 15th. If your employment ends between the 16th and the end of the month, coverage ends on the last day of the month.
- When the TPC Group policy ends.
- The date you are no longer eligible under the Tutor Perini Benefit Plans.
- Upon your death or retirement.
- The end of the month in which you enter the US Armed Forces on a full-time basis – (subject to USERRA).

SPOUSAL SURCHARGE

A monthly spousal/domestic partner surcharge of $150 will be added to your monthly contribution for medical coverage if you elect to cover your spouse/domestic partner and your spouse/domestic partner is eligible for coverage through his/her employer but chooses not to enroll in their employer-provided coverage. The spousal/domestic partner surcharge does not apply if:

- You do not enroll your spouse/domestic partner in the TPC medical coverage.
- Your spouse/domestic partner is not employed.
- Your spouse/domestic partner is employed but is not eligible for medical coverage through his/her employer.
- Your spouse/domestic partner is eligible for and/or is enrolled in Medicare/Medicaid.
- You and your spouse/domestic partner both work at TPC or a TPC affiliated company. Employees who are married/domestic partner, both work at TPC, and want to participate in a TPC medial plan, must elect individual coverage.

You must provide notification within 31 days if:

1) your spouse/domestic partner loses medical coverage, and you wish to add him/her to the Tutor Perini Medical Plan, or
2) your spouse/domestic partner obtains medical coverage through his/her employer, and you wish to remove him/her from the Tutor Perini Medical Plan.

TOBACCO POLICY

Staying healthy and taking care of yourself is its own reward, but it can also help you lower your out-of-pocket costs.

TOBACCO CESSATION PRESCRIPTION DRUG SUPPORT AND SURCHARGE

- A tobacco user is defined as any individual who has used tobacco products (including cigarettes, cigars, pipes, chewing tobacco and e-cigarettes) in the last 6 months.
- You and your spouse/domestic partner will be eligible for a reduced rate (non-tobacco) if you and your covered spouse/domestic partner are non-tobacco users.
- Tutor Perini will impose a surcharge if you and/or your spouse/domestic partner identify as a tobacco user during enrollment. An additional monthly surcharge will apply if you and your spouse/domestic partner are tobacco users.
- If you and/or your spouse/domestic partner are a tobacco user or have used tobacco products including e-cigarettes within the last 6 months, you can qualify for the lower premium by being tobacco free for a minimum of 6 months.

Premium updates will be provided so that members will earn the full reward.

TOBACCO CESSATION PROGRAMS

There are several resources online to assist you and/or your spouse/domestic partner through the process of being tobacco free:

Nicotine Anonymous: Offers telephone and internet meetings in addition to in-person meetings in many locations. Nicotine-Anonymous.org

SmokeFree: Offers telephone and internet counseling. You can call 800-Quit-Now and 800-227-2345 for smoking cessation support. SmokeFree.gov

NOTICE OF AVAILABILITY OF ALTERNATIVE STANDARD FOR WELLNESS

Your Medical Plan is committed to helping you achieve your best health. Rewards for remaining tobacco free are available to all eligible employees. If you think you might be unable to meet a standard for a reward, you might qualify for an opportunity to earn the same reward by different means. Examples of different means are as follows:

- Complete a free online educational Program.
  - Freedom from Smoking – A free online Program from the American Lung Association.
  - Watch three extended personal stories on the impact of smoking provided through the CDC as a quit smoking resource.
- Schedule and attend a “tobacco use counseling” session with your primary care provider to discuss tobacco use.

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.

2. You must make the change within 31 days of the date the event occurs.

3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

Rules for Benefit Changes during the Year

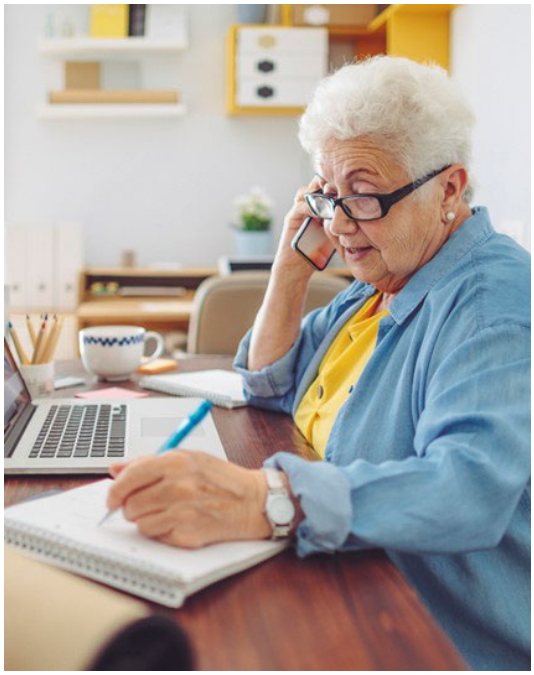
Other than during the annual Open Enrollment period, you may only make changes to your benefit elections if you experience a Qualifying Life Event (QLE) or qualify for a "special enrollment." If you experience a QLE, you may be required to submit proof of change or evidence of prior coverage in accordance with IRS guidelines.

Qualifying Life Event includes:

- Change in legal marital status including marriage/domestic partnership, divorce, legal separation, annulment, and death of a spouse
- Change in number of dependents including birth, adoption, placement for adoption, or death of a dependent child or change dependent eligibility status
- Change in employment status that affects eligibility including the start or termination of employment by you, your spouse, or your dependent child
- Change place of residence or worksite including a change that affects the accessibility of network providers
- Change in your health coverage or your spouse's/domestic partner's coverage attributable to your spouse's employment.
- Change in an individual's eligibility for Medicare or Medicaid
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualifying Medical Child Support Order) requiring coverage for your child(ren).
- An event that is a "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA) including acquisition of a new dependent by marriage/domestic partnership, birth or adoption, or loss of coverage under health insurance Plan.
- An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act. Under provisions of the Act, employees have 60 days after the following events to request enrollment if:
  - Employee or dependent loses eligibility for Medicaid (known as Medi-Cal in CA) or CHIP (known as Healthy Families in CA).
  - Employee or dependent becomes eligible to participate in a Premium Assistance Program under Medicaid or CHIP.

You must submit your change within 31 days after the event.

HAVE QUESTIONS ABOUT YOUR BENEFITS



CONTACT YOUR ALLIANT BENEFIT ADVOCATE

Email: benefitsupport@alliant.com

Phone: 800-489-1390

Hours: 5 a.m. – 5 p.m. PST Monday - Friday

Get Help From Your Benefit Advocate

Are you getting married and not sure how and when to add your new spouse to your plan? Is your stepchild eligible for your healthcare plan? Do you need help understanding the difference between an HSA and an FSA? A Benefit Advocate can help answer these questions and more.

Benefit Advocates are trained benefits expert who can help you understand and use your healthcare and other coverage. Contact your Benefit Advocate for issues such as:

- General benefit questions
- Eligibility and coverage
- Finding a network provider
- Health care claim or billing issues, when warranted
- Coverage changes due to life events (marriage, new child, divorce, etc.).

Claims Assistance

If you need claims assistance, you'll need to complete a HIPAA Authorization Form to grant your Benefit Advocate permission to work with your insurer and/or healthcare provider(s) to resolve your claims issues. Permission is granted on a limited time basis to only the individuals listed on the form. The form is revocable at any time. Your Benefit Advocate will provide the form to you when needed.

MEDICAL

OUR PLAN

AETNA GLOBAL PPO PLAN

We offer one medical plan through **Aetna International**. Review the out-of-pocket costs such as deductible, coinsurance and prescription drugs so you can budget and understand how the plan works.

PPO (Preferred Provider Organization):

- Able to see any provider, even a specialist, without a referral
- Will pay more to see out-of-network providers

Submit a Claim

There are 5 ways to submit a claim for reimbursement of your medical expenses.

1. Upload your claim via our website
2. Email aiservice@aetna.com with your scanned claim form and receipts
3. Use our International Mobile app
4. Mail your completed claim form and receipts to the address on the claim form
5. Fax your completed claim form and receipts to the number on the claim form

Claims may take up to 14 days on average to process. You can always check the status of your claim at AetnaInternational.com.

Medical with Vision

The TPC Medical Plan is the Aetna Global PPO Plan administered by **Aetna International**. Your share of expenses includes a deductible, coinsurance, and copayments. You will pay a lower share of the medical expenses when you use doctors and hospitals that participate in the Aetna PPO network. Although you may receive care and services from out-of-network providers, you share of the cost will be higher.

REGISTER NOW

The most important first step is to register as a member (once enrolled) at www.aetnainternational.com/members/login.do. This site stores important documents that will help you understand your coverage and give you the tools you will need to manage your health benefits. You can register in just a few steps by visiting the member site listed above.

If you have a smartphone, now is also a good time to download our Aetna International Mobile App, which makes it easy to manage your benefits on the go. You can search 'Aetna' in the App Store or Google Play store to get started.

YOUR ID CARD

If you are a new enrollee, you should expect your new ID card to be received within 8 weeks. In the interim you can easily print a new (or replacement) ID card at www.aetnainternational.com once you are registered and login. Click on "Get ID card" and follow the instructions.

FIND A PROVIDER

Outside the United States, you can search our list of providers online by logging in to your www.aetnainternational.com/members/login.do. You can also download our 'Provider Directory' app for your smartphone. **Inside the United States**, visit www.aetna.com. And of course, you can always call the Member Service Center for assistance.

USE AN IN-NETWORK PROVIDER WHENEVER POSSIBLE

When you visit any in-network hospital or clinic you will not only get quality care, but you will also be able to reduce your out-of-pocket expenses at time of service. This is called a "direct settlement", meaning that you pay the co-pay or coinsurance up front, and the provider 'settles' the balance of the claim directly with Aetna.

Here are just a few of the advantages:

- Lower out-of-pocket cost at the time of service
- Easier claim submissions
- Numerous reimbursement and prepayment choices
- Verification of Benefits letters sent directly to the treatment facility

If you would like to see an out-of-network provider, Aetna can help you. However, please note that in most cases you will have to pay more if you go to a provider outside of our network. Call the number on the back of your Aetna ID Card to arrange payments with an out of network provider.

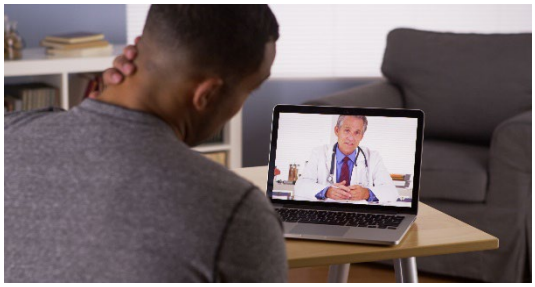
GET ASSISTANCE FROM ONE OF OUR CLINICIANS

Aetna's International Health Advisory Team of clinicians is available 24/7/365 to provide one-on-one support.

Services include:

- Pre-trip guidance and resources
- Help finding doctors and facilities
- Worldwide coordination of routine and urgent medical care
- Help obtaining prescriptions and medical devices
- Coordination of care for return to home country & Discharge planning

WHEN YOU NEED CARE NOW



GET THE CARE YOU NEED

Teladoc Health doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Sinus problems
- Urinary tract infection
- Respiratory infection
- Skin problems
- And more!

Talk to a Doctor Anytime

Teladoc Health gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone, video or mobile app visits. It's an affordable alternative to costly urgent care and ER visits when you need care now.

Teladoc Health is just a call or click away!

Teladoc.com | 800-Teladoc

As an expat you have access to Teladoc services if you are physically in the U.S. at the time of service.

Meet Our Doctors

Teladoc Health is simply a new way to access qualified doctors. All Teladoc Health doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 20 years' experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

When Should I use Teladoc Health?

Teladoc Health does not replace your primary physician. It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care for a non-emergency
- When on vacation, a business trip or away from home
- For short-term prescription refills

How do I Access Teladoc Health?

Set up your account today so when you need care now, a Teladoc doctor is just a call or click away. It's two simple steps and you will be able to talk to a doctor anytime.

- Step 1: Go to teladoc.com and click "Set up Account" and provide the required information. You can also call Teladoc at 800-835-2362. And don't forget to download the mobile app by visiting teladoc.com/mobile.
- Step 2: Once your account is set up, request a consult anytime you need care.

Teladoc Behavioral Health

Speak with a licensed therapist from anywhere. Taking care of your mental health is an important part of your overall well-being. With Teladoc's Mental Health, adults 18 and older can get care for anxiety, depression, grief, family issues, and more. Choose to see a psychiatrist, psychologist, social worker, or therapist and establish an ongoing relationship.

Teladoc doesn't offer a crisis hotline. Appointments must be scheduled.

Why use Teladoc's Mental Health service:

- Confidential treatment
- Convenience to speak with a therapist from anywhere
- Flexible scheduling
- Quick access to the right provider for you

To schedule a visit, you must register your Teladoc account. Once you are registered, or if you're already registered:

- Request a visit
- Answer a few questions
- Select your therapist
- Request a time for your appointment

MEDICAL WITH VISION

The Medical Plan available is the PPO Global Plan which is administered by **Aetna International**. If you enroll in the PPO Global Medical Plan offered by Tutor Perini, you will receive Vision benefits through **Aetna**.

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

.	Aetna Global Medical		
	Outside the U.S.	In the U.S	
		In-Network	Out-of-Network[1]
Annual Deductible Individual Family	$0 $0	$1,500 $3,000	$3,000 $6,000
Out-of-Pocket Maximum[2] Individual Family	$0 $0	$3,000 $6,000	$6,000 $12,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Office Visit Primary Care Specialist	No charge No charge	$30 copay $30 copay	50% * 50% *
Online Visit (Teladoc)	Not covered	No charge	Not covered
Routine Adult Physicals	No charge (up to $1,000/year max)	No charge	50% *
Routine Mammograms	No charge	No charge	50% *
Lab, X-ray & Diagnostics Tests	No charge	20% *	50% *
Inpatient Hospitalization	No charge	20% * after $250 confinement copay	50% * after $500 confinement copay
Outpatient Surgery	No charge	20% *	50% *
Urgent Care	No charge	$75 copay	50% *
Emergency Room	No charge (true emergency)	$200 copay (waived if admitted)	$200 copay (waived if admitted)
Mental Heath/Substance Abuse Outpatient Inpatient	No charge No charge	$30 copay 20% * after $250 confinement copay	50% * 50% * after $500 confinement copay
Vision Exam (1 routine exam/calendar year)	No charge	No charge	50% *
Vision Supply	No charge[3]	No charge[3]	No charge[3]
International Employee Assistance Program	5 counseling sessions per issue per year	5 counseling sessions per issue per year	5 counseling sessions per issue per year
PRESCRIPTION DRUGS (Aetna International)			
Retail- 30 Day Supply Generic Brand Formulary Brand Non-Formulary	No charge No charge No charge	$15 copay[4] $35 copay[4] $50 copay[4]	50% * 50% * 50% *

*Benefits with an asterisk require the deductible to be met first before the coinsurance applies.

[1]Based on reasonable and customary (amount determined by your health plan as the normal range of payment for a specific health-related service or medical procedure within a given geographic area)
[2]Does not include benefit penalties, 50% items and Outpatient Prescription Drugs. Includes Outpatient Prescription Drugs when outside the US
[3]Up to $125 maximum benefit once every 12 months
[4]Includes Mail Order. Mail Order only mails to locations in the United States

YOUR BENEFIT COSTS

The total amount that you pay for your benefits coverage depends on how many dependents you cover and your tobacco status. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

MEDICAL

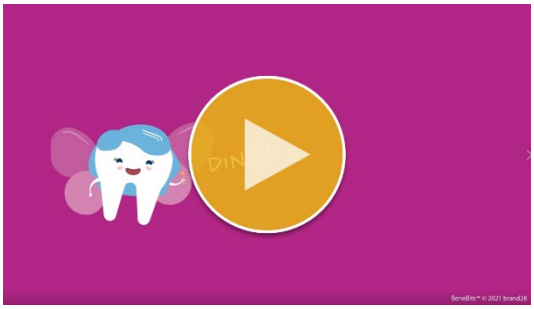
	Monthly	Semi-Monthly	Weekly
Aetna Global PPO (Non-Tobacco)			
Employee Only	$140.20	$70.10	$32.35
Employee + Spouse/DP	$414.90	$207.45	$95.75
Employee + Children	$339.31	$169.66	$78.30
Employee + Family	$537.74	$268.87	$124.09
Aetna Global PPO (Tobacco)			
Employee Only (Tobacco User)	$371.83	$185.92	$85.81
Employee + Spouse/DP (One or More Tobacco User)	$646.53	$323.27	$149.20
Employee + Children (One Tobacco User)	$570.94	$285.47	$131.76
Employee + Family (One or More Tobacco User)	$769.37	$384.69	$177.55

DENTAL

OUR PLAN

AETNA DENTAL PPO

Click to play video



We offer one dental plan through **Aetna International**.

Why Sign Up For Dental Coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers four types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

DENTAL

Our Dental Plan is administered by **Aetna International**.

Regular visits to your dentist can help more than protect your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

You always pay the deductible and copayment ($). The coinsurance (%) shows what the plan pays after the deductible.

	AETNA GLOBAL DENTAL PPO		
	Outside of the U.S.	In the U.S.	
		In-Network	Out-of-Network
Annual Deductible (waived for Diagnostic and Preventive Services)	$75 Individual $150 Family	$75 Individual $150 Family	$75 Individual $150 Family
Annual Plan Maximum	$1,250	$1,250	$1,250
Diagnostic & Preventive	Plans Pays 100%	Plans Pays 100%	Plans Pays 90%
Basic Services	Plans Pays 80%	Plans Pays 80%	Plans Pays 70%
Major Services	Plans Pays 50%	Plans Pays 50%	Plans Pays 50%
Orthodontia Adults & Children (up to age 20)	Plans Pays 50% up to a $1,250 lifetime max	Plans Pays 50% up to a $1,250 lifetime max	Plans Pays 50% up to a $1,250 lifetime max

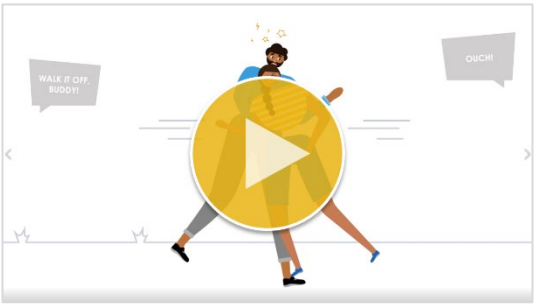
COST OF COVERAGE – Per Paycheck	Monthly	Semi-Monthly	Bi-Weekly	Weekly
Employee Only	$32.48	$16.24	$14.99	$7.50
Employee + Spouse/DP	$69.87	$34.94	$32.25	$16.12
Employee + Child(ren)	$75.34	$37.67	$34.77	$17.39
Employee + Family	$91.27	$45.64	$42.12	$21.06

What you need to know about this plan?

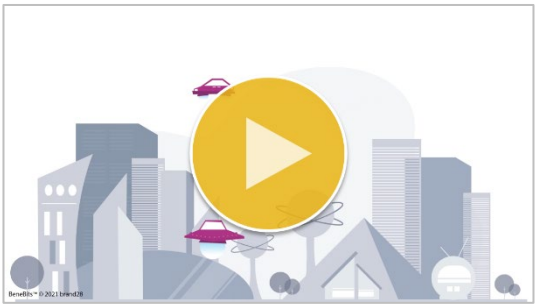
Features:	See any provider, but you'll pay more out of network
Am I restricted to in-network providers?	No
Do I have to select a primary dentist?	No
Where can I get more details?	Visit the Aetna Dental website or app.

ENGAGE

Click to play video



Urgent Care vs ER



Virtual Healthcare

Maximize Your Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs
- Mobile Resources

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline	Quick answers from a trained nurse	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	**$0**
Online visit	Many non-emergency health conditions	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	**$**
Office visit	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	**$$$$$**

ALTERNATIVE FACILITIES

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Need	Alternative	Features	Savings
Surgery	Ambulatory Surgery Center (ASC)	▪ Specializes in same-day surgeries ▪ Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more ▪ Held to same safety standards as hospitals	Up to 50% over hospital stay*
Physical therapy	Free-standing physical therapy center	▪ Important part of the recovery process after an injury or surgery	40 to 60% over a hospital setting*
Sleep study	Home testing	▪ Diagnoses sleep apnea and other conditions ▪ Cost is often covered by insurance if considered medically necessary	Approx. $4,500*
Infusion therapy	Home or outpatient infusion therapy	▪ For drugs that must be delivered by intravenous injections, or epidurals ▪ Delivered by licensed infusion therapy provider ▪ Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% over hospital stay* **in-network*

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, etc. on your plan's website; or call member services for assistance.

Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings. Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

PREVENTIVE CARE SCREENING BENEFITS

TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit **healthcare.gov/coverage/preventive-care-benefits/** for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

MOBILE RESOURCES

ACCESS YOUR BENEFITS ANYTIME, ANYWHERE

Most of our carriers and vendors have mobile apps available making accessing your benefits information easier than ever.

Just download the apps via the Apple App Store and Google Play and make sure to share with your dependents!

Download on the App Store

GET IT ON Google Play

- **AETNA INTERNATIONAL MEDICAL:** Aetna International medical members can find a network provider, get estimates for most procedures, view your medical plan summary, view deducible and out of pocket amounts, search claims, and view ID cards.
    - **TELADOC**: Aetna International members also have access to Teladoc via the mobile app. Easily schedule virtual visits and meet with a provider within minutes. Available only in the U.S.
- **AETNA INTERNATIONAL DENTAL:** Aetna Dental members can find a network dentist, view plan summaries, use the treatment cost estimator, and view ID cards.
- **WORKDAY MOBILE APP:** Access current benefits information, beneficiaries, important documents, ID cards, contact information and much more! To access, download the “Workday” app on your mobile device.

LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D and Disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide a base amount of life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary life coverage that you can purchase for yourself, your spouse, and your children.

You can also purchase short and long-term disability benefits to supplement your income should you become ill, disabled or unable to work.

BASIC LIFE AND AD&D INSURANCE

LIFE AND AD&D (COMPANY PAID)

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if as a result of an accident, you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by Tutor Perini. Coverage is provided by **The Standard**.

For employees who earn $150,000 per year or more, your life benefit will be supplemented with Group Universal Life Coverage (GUL) through **MetLife**.

BASIC LIFE	Earnings Based Benefit
Employees earning below $100,000	Flat $30,000
Employees earning between $100,000 and $149,999	One times annual base earnings, max of $150,000
Employees earning between $150,000 and $249,999	Flat $50,000 and enrollment in MetLife GUL with a combined basic life coverage of one times your annual base salary, up to a benefit max of $1,500,000
Employees earning $250,000 and above	Flat $50,000 and enrollment in MetLife GUL with a combined basic life coverage of two times your annual base salary, up to a benefit max of $1,500,000

Note: Employees who are eligible for MetLife's Basic GUL will work directly with MetLife. If you are over the age of 70 MetLife will require EOI.

BASIC AD&D	Earnings Based Benefit
Employees earning below $100,000	Flat $30,000
Employees earning between $100,000 and $249,999	One times annual base earnings, Max of $250,000
Employees earning at or above $250,000	Two times annual base earnings. Max of $350,000

Benefit Reduction Schedule

Age 70	65% of original amount
Age 75+	50% of original amount

A NOTE ABOUT TAXES

The premium amount Tutor Perini pays The Standard for your life insurance coverage exceeding $50,000 is included in your income and is defined as imputed income. The taxable amount is determined by the IRS. Imputed income for the MetLife Group Universal Life coverage will equal the premium Tutor Perini paid on your behalf.

BASIC LIFE AND AD&D INSURANCE

THE STANDARD VALUE ADDED PROGRAMS

These services are available at no additional cost to individuals who have The Standards' Basic Life and AD&D. Click the links to learn more about each program.

TRAVEL ASSISTANCE: Rely on Travel Assistance when you're away from home. Travel Assist can help you with:

- Passport, visa and currency exchange information, health hazards advice and inoculation requirements
- Help replacing prescription medication or lost corrective lenses and advancing funds for emergency medical payment
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains

LIFE SERVICES TOOLKIT: Timely and compassionate support services for you and your beneficiaries.

- **Estate-planning Assistance**: Online tools walk employees through the steps to prepare a will and create other documents, such as living wills, powers of attorney and health care agent forms.
- **Financial Planning:** Online tools help employees confidently manage debt, calculate mortgage and loan payments, and take care of other financial matters.
- **Funeral Arrangements:** Employees can use the website to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements in advance.
- **Greif Support:** Clinicians are on call to provide confidential grief support to beneficiaries by phone or in person. Beneficiaries are eligible for up to six face-to-face grief sessions and unlimited phone contact.

HEALTH ADVOCACY SELECT:

At no additional cost, for those with an active STD claim you can contact Health Advocate™ and be assigned a Personal Health Advocate, typically a registered nurse, who will remain on your case until it's fully resolved.

- Make sense of your diagnosis and research treatment options.
- Find and schedule appointments with the right doctors and specialists, particularly for complex medical conditions where a second opinion is appropriate.
- Manage your out-of-pocket expenses by finding alternative services and cost information.
- Resolve medical claims and billing issues.
- Find resources for services that may not be covered through your employer's health benefits program.

CLAIM STATUS TEXT UPDATES:

Get updates on claims already filed with the Standard. They will let you know when key documents are received and will keep you informed of your claim.

FOR ASSISTANCE, CONTACT:

Travel Assistance:	**Email:** medservices@assistamerica.com **Website:** standard.com/travel **App:** App Store and Google Play **Phone:** 800-872-1414 US, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda) 609-986-1234 (Everywhere else)
Life Services Toolkit:	**Website:** standard.com/mytoolkit **User name:** assurance 800-378-5742
Health Advocacy Select:	844-450-5543; Monday - Friday, 8 a.m. - 11 p.m.
Claim Status Text Updates:	Text STATUS to 5328

SUPPLEMENTAL LIFE INSURANCE

(EMPLOYEE PAID)

VOLUNTARY LIFE

Tutor Perini provides you the opportunity to purchase additional life insurance through **The Standard** for all employees earning under $150,000 annually.

Employees earning $150,000 or more will have the opportunity to purchase supplemental coverage through **MetLife,** not The Standard.

	Benefit
Employee	Minimum: $10,000 Maximum: Lesser of $500,000 or 6x annual earnings (cannot exceed combined Basic & Voluntary) Increments of: $10,000
Spouse	Minimum: $5,000 Maximum: $100,000 (cannot exceed 50% of employee amount) Increments of: $5,000
Child(ren)	Minimum: $2,500 Maximum: $10,000 (cannot exceed 50% of employee amount) Increments of: $2,500

Note: Employees who are eligible for MetLife's Supplemental GUL will work directly with MetLife.

GUARANTEE ISSUE MAXIMUM

For newly eligible employees, there is a maximum amount of coverage you may apply for during the 2026 enrollment without answering health questions.

Employees: $150,000
Spouses: $60,000
Children: $10,000

You will receive a "To Do" step in your Workday inbox, which contains additional information and the link to submit EOI to The Standard for approval.

Supplemental GUL coverage may also require EOI. MetLife will reach out and provide EOI forms when necessary.

	Monthly Rate per $1,000	
	Tobacco User	**Non-Tobacco User**
Under age 30	$0.16	$0.09
Age 30 – 34	$0.18	$0.09
Age 35 – 39	$0.24	$0.11
Age 40 – 44	$0.43	$0.18
Age 45 – 49	$0.80	$0.33
Age 50 – 54	$1.45	$0.62
Age 55 – 59	$2.32	$1.06
Age 60 – 64	$2.96	$1.49
Age 65 – 69	$4.20	$2.35
Age 70 – 74	$5.68	$3.59
Age 75+	$12.24	$9.74
Child(ren) Monthly Rate	$0.05 per $1,000; regardless of the number of children enrolled	

Rate is based on your own age, either employee or spouse, as of January 1st .

VOLUNTARY SHORT-TERM DISABILITY INSURANCE (STD)

(NON-CA ONLY, EMPLOYEE PAID)

EXPECT THE UNEXPECTED

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

SUBMITTING A CLAIM

If you are disabled due to an illness or accidental injury, unable to work, and under the care of a licensed physician, you are eligible to submit a claim for benefits under this plan. As long as you remain disabled and meet the plan's disability requirements, you will continue to receive a percentage of your earnings until benefits are no longer payable.

Short-Term Disability (STD) insurance replaces part of your income for non-occupational limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. This benefit would be reduced by any state, federal or private disability Plan coverage. You pay the cost of this coverage. Coverage is provided by **The Standard**.

The following states have state disability income replacement: California, New York, New Jersey, Hawaii and Rhode Island.

CA Employees: You do not have access to Voluntary Short-Term disability through the Standard. The California state disability program offers a benefit that is richer than the Standard's Voluntary Short Term Disability program.

Weekly Benefit Amount	Plan pays 60% of weekly earnings
Maximum Weekly Benefit	$1,100
Benefits Begin After Accident Sickness	 7 days of disability 7 days of disability
Maximum Payment Period[1]	173 days

[1]Maximum payment period is based on the first day benefits begin, not the first day you are disabled. This does not include the Elimination Period.

EVIDENCE OF INSURABILITY

If you did not enroll when you were initially eligible for coverage, you will be able to enroll during future open enrollments as a Late Entrant without having to submit evidence of insurability. You will be automatically approved, however there will be a late entrant provision which is a 60-day waiting period during the 12-month period beginning on the date your insurance becomes effective. This 60-day waiting period is for physical disease, pregnancy or mental disorder. This does not apply to accidents. Please note you can only enroll in this coverage when you are first eligible as a new hire or during annual open enrollment.

Note: If you move from California to another state, you will have 31 days to elect STD as a newly eligible employee, meaning the 60-day late entrant provision would not apply.

VOLUNTARY LONG-TERM DISABILITY INSURANCE (LTD)

(EMPLOYEE PAID)

4 THINGS TO KNOW ABOUT LTD INSURANCE

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.
4. Benefits are tax-free, since you pay the premiums with after-tax dollars.

LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled You pay the cost of this coverage. Coverage is provided by The Standard.

EVIDENCE OF INSURABILITY

Employees who did not originally enroll when first eligible will need to submit Evidence of Insurability.

Long Term Disability Benefit

	50% Plan	60% Plan
Monthly Benefit Amount	50% of covered monthly earnings	60% of covered monthly earnings
Maximum Monthly Benefit	$15,000	$15,000
Elimination Period	180 days	180 days
Maximum Payment Period[1]	5 years	Social Security Normal Retirement Age

[1] The age at which the disability begins may affect the duration of the benefits.

LONG TERM DISABILITY BENEFIT REDUCTION SCHEDULE

If you become disabled after normal retirement age (differs depending on your birth year), your maximum benefit period will decrease (see below).

Maximum Benefit Period

	50% Plan	60% Plan
Age 62	5 years	To age 65, or to SSNRA, or 3 years 6 months, whichever is longer
Age 63	3 years	To SSNRA, or 3 years, whichever is longer
Age 64	2 years 6 months	To SSNRA, or 2 years 6 months, whichever is longer
Age 65	2 years	2 years
Age 66	1 year 9 months	1 year 9 months
Age 67	1 year 6 months	1 year 6 months
Age 68	1 year 3 months	1 year 3 months
Age 69+	1 year	1 year

DISABILITY INSURANCE RATES

SHORT TERM DISABILITY

	Monthly Rate per $10 of Benefit
	Non-California Employees
Under age 45	$0.680
Age 45-49	$0.718
Age 50-54	$0.889
Age 55-59	$1.129
Age 60-64	$1.368
Age 65+	$1.496

LONG TERM DISABILITY

	Monthly Rate per $100 of Monthly Covered Earnings	
	50% Plan	60% Plan
Under age 25	$0.05	$0.10
Age 25-29	$0.06	$0.13
Age 30-34	$0.12	$0.23
Age 35-39	$0.18	$0.36
Age 40-44	$0.26	$0.54
Age 45-49	$0.35	$0.73
Age 50-54	$0.50	$1.02
Age 55-59	$0.52	$1.08
Age 60-64	$0.55	$1.13
Age 65-69	$0.57	$1.18
Age 70+	$0.59	$1.21

Sample Non-CA STD Plan Premium Calculation:

45 year old Non-CA Employee earning $32,000

(1) $32,000 / 52 weeks = $615.38 weekly earnings
(2) $615.38 x 60% = $369.23 weekly benefit
(3) $369.23 / $10 = $36.92
(4) $36.92 x $0.718 = $26.51 per month

Sample 50% LTD Plan Premium Calculation:

45 year old Employee earning $32,000

(1) $32,000 / 12 = $2,666.67 monthly earnings
(2) $2,666.67 / $100 = $26.67
(3) $26.67 x $0.35 = $9.33 per month

Same calculation applies for 60% LTD plan, use 60% LTD plan rate

ADDITIONAL BENEFITS

ADDITIONAL COMPANY PAID BENEFITS

Alliant Medicare Solutions (AMS)

Business Travel Accident

Leave of Absence

More Benefits for your Life and Work Changes

Tutor Perini offers even more company paid benefits to help support your life and work changes when you need them most.

Whether you need assistance with understanding and enrolling in Medicare, additional insurance during work travel or you need to take a leave of absence from work, Tutor Perini has you covered!

PREMIER

NEARING 65? GET TO KNOW MEDICARE

Alliant
MEDICARE SOLUTIONS
A Non-Government Entity

amspremier.com

Alliant Medicare Solutions Premier is provided by Transitions RBG LLC, a Georgia resident insurance agency. Transitions RBG LLC is wholly owned by Alliant Insurance Services, Inc.

Important deadlines ahead

Most people become eligible for Medicare at age 65. At that time, you'll need to make some important decisions about your health insurance.

But the choice isn't always easy. Maybe you'll keep working after 65. Maybe you have dependents covered by your Tutor Perini sponsored insurance. Maybe you're just not sure which options could work best for your situation.

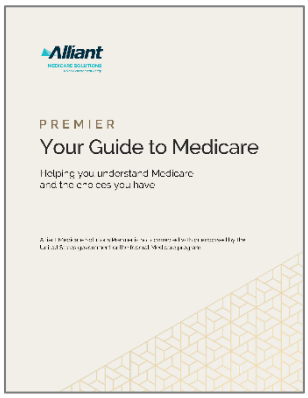
Alliant Medicare Solutions Premier

Through Tutor Perini, you have access to Alliant Medicare Solutions Premier, a free service you, your family, and your friends can use to figure out the best Medicare options for you.

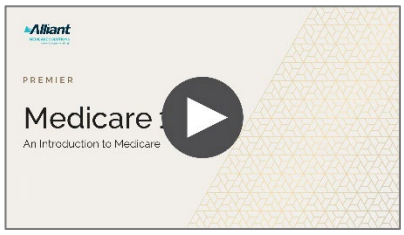
How it works

- Gather your current health insurance information.
- Call Alliant Medicare Solutions Premier at **(877) 638-1413** to talk to a licensed insurance agent about your current coverage, your Medicare options, and what might work best for your situation.
- Alliant Medicare Solutions Premier can help you enroll in Medicare or email policy information for you to review.

Learn more



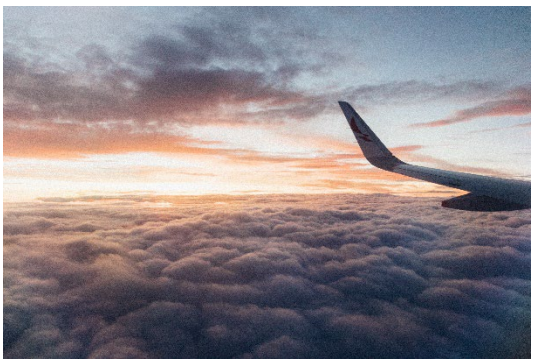
Your Guide to Medicare



Medicare 101

Social Security Planning

BUSINESS TRAVEL ACCIDENT



Business Travel Accident

Tutor Perini provides Business Travel Accident insurance to employees while traveling on approved travel for the Company provided that the travel is to a point other than their normal work location. This benefit is administered through **NYL Group Benefit Solutions** (formerly CIGNA).

Benefit	$250,000
Aggregate Limit	$2,500,000 per accident (if more than one person suffers a loss as a result of the same accident)
Benefit Reduction	Age 70 – 74: 65% of original amount Age 75 – 79: 45% of original amount Age 80 – 84: 30% of original amount Age 85+: 15% of original amount
General Exclusions	Suicide, declared or undeclared war, travel or flight in or on any vehicle used for aerial navigation, infections or any kind regardless of how contracted, and sickness, disease, mental incapacity, or bodily infirmity.

LEAVE OF ABSENCE

Our Leave Administration is managed by **The Standard**.

REPORTING ABSENCES

It feels good to be prepared. You are able to report an absence with Standard Insurance Company if you become disabled or need to file for a leave of absence from work.

WHEN SHOULD I REPORT AN ABSENCE?

Contact The Standard if you are, or will be absent from work for any of the following reasons:

- Your own serious health condition (including pregnancy)
- To care for your newborn child
- The placement of your adopted or foster child
- To provide care for a qualifying family member with a serious health condition
- To care for a covered service member injured in the line of duty
- For qualifying military need, allowing family members to take leave to prepare for or deal with issues that arise as a result of a family member being called to serve the military
- Work-related injury/illness

FOR ALL OTHER ABSENCES: Please follow the normal Tutor Perini absence reporting procedures and notify your department head, manager or local HR Director. Tutor Perini has an FMLA leave reporting provision giving you 10 calendar days from the date of your first absence to file for FMLA.

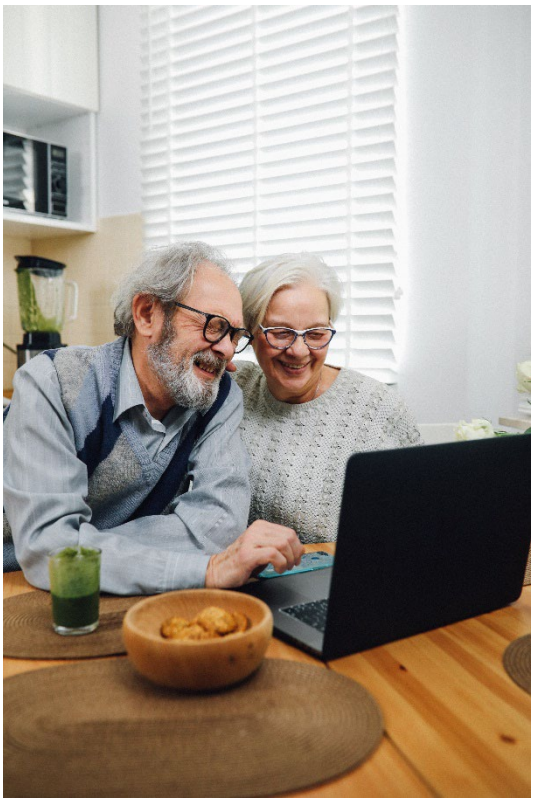
HOW DO I NOTIFY THE STANDARD ABOUT AN ABSENCE?

Call the Absence Management Service Center at 866-756-8116 (M-F 5am – 5pm PST) or log in at Standard.com. First time users will need to create an account. The website has a step-by-step guide on how to do this. The website lets you report an absence for yourself and view leave information and status.

WHO IS RESPONSIBLE FOR NOTIFYING TUTOR PERINI ABOUT MY ABSENCE?

It is your responsibility to follow the normal Tutor Perini absence reporting procedures and notify your department head or manager of your absence.

IMPORTANT PLAN INFORMATION



In this section, you'll find important plan information, including:

- Contact information for our benefit carriers and vendors
- A Benefits Glossary to help you understand important insurance terms.
- A summary of the health plan notices you are entitled to receive annually, and where to find them

PLAN CONTACTS

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Claim Office	Member Services	Policy No.
Aetna Global Benefits	Aetna International	Aetna Global Benefits P.O. Box 981543 El Paso, TX 79998-1543	AetnaInternational.com	733805
International Employee Assistance Program (EAP)	Aetna International	N/A	800-231-7729	733805
Basic Life and AD&D, Supplemental Life, STD, LTD	The Standard Insurance Company	900 SW Fifth Avenue, Portland, OR 97204	T: 800.368.2859 F: 800.378.6053 www.standard.com	166454
Group Universal Life Plan	MetLife	Please contact Human Resources	800-756-0124 8am-8pm (EST)M-F Enrollment Website: mybenefits.metlife.com	Tutor Perini
Business Travel Accident	NYL Group Benefit Solutions	Pittsburgh Claim Service Center P.O. Box 22328 Pittsburgh, PA 15222-0328	800-238-2125	ABL962767
Medicare Solutions	Alliant Medicare Solutions - Premier	N/A	877-638-1413	Tutor Perini
Leave Administrator	The Standard	Standard Insurance Company Employee Benefits Division PO Box 3877 Portland, OR 97208	866-756-8116 866-751-5174 Standard.com/Absence	166454
Benefit Advocate	Alliant	N/A	800-489-1390 benefitsupport@alliant.com	N/A

For General Enrollment & Benefit Questions, please contact your local Human Resources Office.

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children underage 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.
Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available within this guide.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **Notice Regarding Wellness Program:** Describes voluntary nature of wellness program that includes biometrics and/or a Health Risk Assessment (HRA)
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

DEADLINE FOR FILING LAWSUIT UNDER ERISA AFTER EXHAUSTION OF ALL CLAIMS PROCEDURES

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of all claims and appeals procedure is required prior to filing suit. Please refer to the WRAP Summary Plan Description for the plan specific statute of limitations.

PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available through Human Resources. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- **Tutor Perini Corporation Health and Welfare Plan**

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. For SBC documents, please contact your local Human Resources.

- **Aetna Global PPO**

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Tutor Perini Corporation Health and Welfare Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Medicare Part D Notice

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Tutor Perini Corporation has determined that the prescription drug coverage offered by the Aetna Global PPO plan are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your Tutor Perini Corporation coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under the Aetna Global PPO plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Tutor Perini Corporation prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	01/01/2026
Name of Entity/Sender:	Tutor Perini Corporation
Contact-Position/Office:	Human Resources
Address:	15901 Olden Street, Sylmar, CA 91342
Phone Number:	818-362-8391

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance listed in the Aetna Global materials apply. If you would like more information on WHCRA benefits, call your plan administrator.

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 on maternity benefits, call your plan administrator.

Notice of Availability of Alternative Standard for Wellness Plan

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your plan administrator and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Tutor Perini Corporation's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Tutor Perini Corporation's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Tutor Perini Corporation's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Tutor Perini Corporation describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting your administrator.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.02% in 2025 of your modified adjusted household income.

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

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

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

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

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

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

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ | Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com | Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ | HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2
INDIANA – Medicaid
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ | http://www.in.gov/fssa/dfr/ | Family and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services | Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services | Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ | Phone: 1-800-657-3672
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html | Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov | Phone: 1-888-222-2542 | Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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CORPORATION