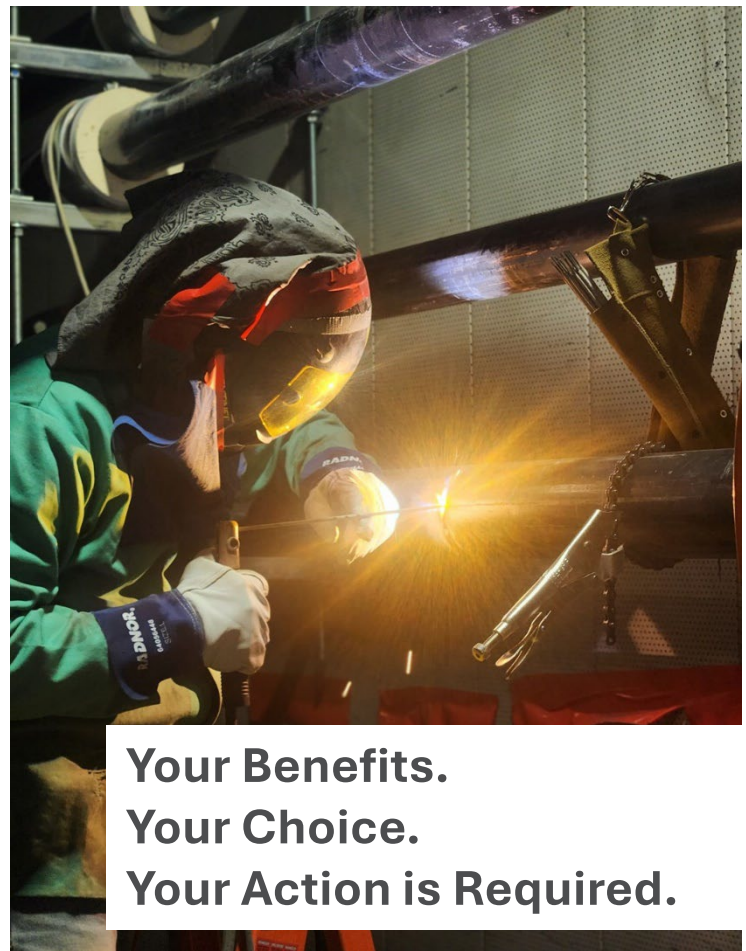
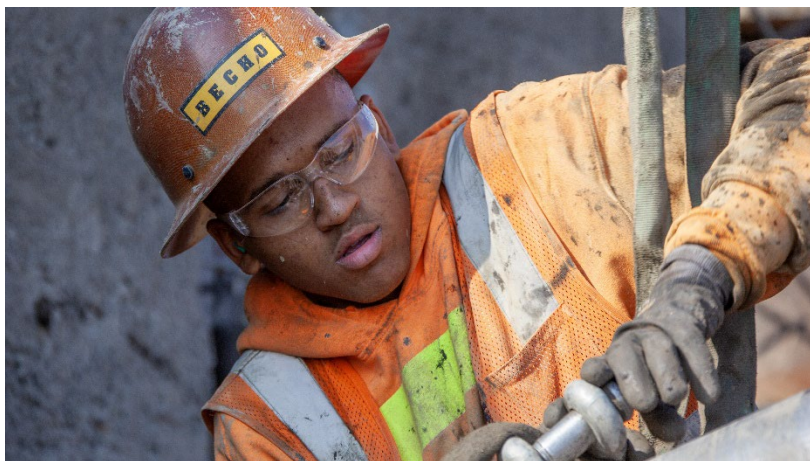




**Your Benefits.
Your Choice.
Your Action is Required.**

**2026 BENEFITS
FULL TIME EMPLOYEES**

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.

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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

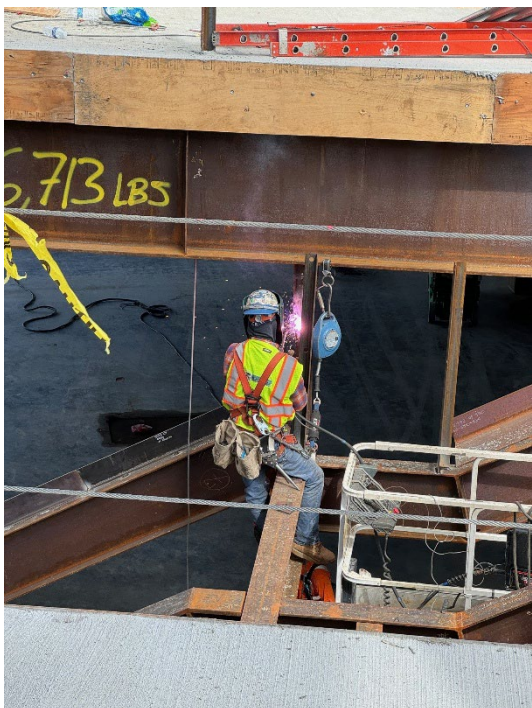
2026 BENEFITS

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, retirement benefits, 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 your 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 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 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 medical 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.

In addition, Tobacco Cessation Prescription Drug Support is included in our plans to encourage and assist you and/or your spouse/domestic partner to stop smoking. Some tobacco cessation prescriptions are available at no copay. A list of those drugs is available through OptumRx.

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

The Tutor Perini benefits also have programs to assist you and/or your spouse/domestic partner:

OptumEAP: Call our Employee Assistance Program (EAP) provided by Optum at 1-866-248-4096 for smoking cessation resources in your community.

Blue Shield: Smoking cessation assistance and tools can be found on the Blue Shield website. Employees have access to the Clickotine program through Wellvolution®.

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 PLANS

BLUE SHIELD HDHP PLAN

BLUE SHIELD PPO PLAN

We offer two medical plans through Blue Shield. Review the out-of-pocket costs such as deductible, coinsurance and prescription drugs so you can choose the best fit for your health concerns and budget/understand how the plan works.

Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

Consider a High Deductible Health Plan (HDHP) if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers
- You want tax-free savings on your healthcare costs
- You want to build a savings account for future healthcare costs for you and your eligible family members
- You want an extra way to add to your retirement savings

Consider a PPO (Preferred Provider Organization) if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers
- You prefer to access some benefits without having to meet a deductible first.

UNDERSTANDING PLAN TYPES

Tutor Perini offers two medical plan types so that you can pick the plan that best fits your budget and healthcare needs.

Both HDHPs and PPOs allow you to see any doctor, but you will pay a higher coinsurance percentage if the doctor is out-of-network.

	HDHP High Deductible Health Plan	PPO Preferred Provider Organization
Deductible	✓	✓
Out-of-Network Care Covered	✓	✓
Referral Needed to see Specialist		
Must select Primary Care Physician		
Pros	You can go anywhere, whether in-network or out-of-network, but with the advantage of a tax-free Health Savings Account	- You can go anywhere, whether in-network or out-of-network - You prefer access to some benefits without having to meet a deductible first
Cons	- You pay more for out-of-network providers - More responsibility for out-of-pocket costs until the deductible is met	You pay more for out-of-network providers

Click to play video



All About Medical Plans

Medical plans can seem hard to understand, but once you understand the building blocks you will be able to choose the best plan for you and your dependents.

PERSONALIZED HEALTH AND BENEFIT SUPPORT



Activate your Accolade account at member.accolade.com. Download the Accolade mobile app for support on the go!

Phone number: 866-336-0791



To learn more, visit regenexxbenefits.com/tutorperini

Phone number: 866-582-4686

Accolade

Tutor Perini partners with Accolade to provide you with convenient and high-quality healthcare that saves you money — no matter where you are on your healthcare journey.

Accolade can help you:

- Find high-quality, in-network doctors and other providers
- Understand insurance coverage and costs
- Understand medical bills and claims
- Learn about all your TPC medical benefits
- Select the right health plan
- And so much more!

Personalized Benefits Guidance

Get answers to your health and benefits questions from your Health Assistant and nurse — at no cost.

- View and access benefits that would be helpful for you and your family
- Discuss symptoms and find in-network care
- Understand coverage, costs and confusing medical bills

Accolade Care - Virtual Care

See a doctor or therapist from your phone, tablet or computer — day or night.

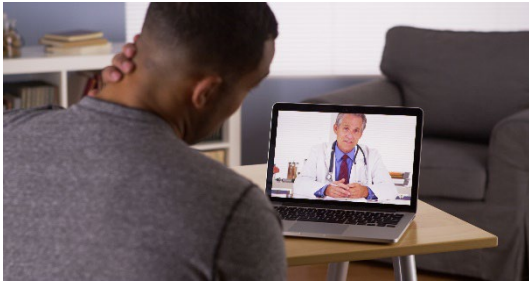
- 24/7 support from your Care Team
- Providers available in all 50 states + D.C.
- Same and next-day virtual primary care visits
- Urgent care, ongoing conditions, mental health, prescriptions and more

Regenexx

Regenexx offers you a choice in treatment for musculoskeletal and orthopedic injuries. You have access to the Regenexx procedures as a covered benefit under the Tutor Perini healthcare plan.

What is Regenexx? Regenexx uses your body's natural healing agents to replace the need for up to 70% of elective orthopedic surgeries by using your stem cells and blood platelets to treat your damaged bone, cartilage, muscle, tendon, and ligament tissues.

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!

blueshieldca.com/teladoc | 800-Teladoc (835-2362)



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 blueshieldca.com/teladoc and click "Log in" under "Access Teladoc now". Log in or create an account on blueshieldca.com. Once you are logged in to your Blue Shield account go to "Get help" and click to "Request a consult" under "Talk to a doctor 24/7/365". Provide the requested information to register for Teladoc.
- **Step 2:** Once your account is set up, request a consult anytime you need care. You can call Teladoc at 800-835-2362. Don't forget to download the Blue Shield mobile app from the App StoreSM or Google PlayTM and click register.

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, members aged 13 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

BLUE SHIELD RESOURCES



Our medical coverage provides our Blue Shield members with a variety of helpful health and wellness resources at no cost. As a Blue Shield member, we encourage you and your eligible family members to register at blueshieldca.com to access tools to help you improve your health, make informed decisions about your care, and find options to save you money.

Virtual Or Walk-in Health Care at CVS and Target (PPO Members Only)

You can get virtual and/or in-person non-emergency health care from CVS Pharmacy® at MinuteClinics and Target Clinics across California. Staffed by board-certified nurse practitioners, CVS and Target offer affordable access to care seven days a week, including evenings and weekends. You may need an appointment for a visit. Hours of operation and a full list of services are available at www.minuteclinic.com and www.target.com/clinic.

Safeguard your identity and your credit

Protecting your financial well-being is as important as protecting your health. As an eligible Blue Shield member, you can get identity protection services from Experian® such as identity repair assistance, identity theft insurance, and credit monitoring for you and your covered family members at no additional cost to you.

You can access these services by contacting Experian's customer care team at (866) 274-3891, Monday to Friday from 8 a.m. to 10 p.m. and Saturday and Sunday from 10 a.m. to 7 p.m. Central time. To learn more, visit experianidworks.com/blueshieldca. When creating your account online, you will need to provide the activation code **BCBSCALI24**. For over-the-phone setup, you will need engagement number **B100349**.

BlueCard – Stay covered while traveling

When you're outside of California or out of the country, you and your family can get urgent and emergency care through the BlueCard® and Blue Shield Global Core programs. These programs offer access to doctors and hospitals almost everywhere in the U.S. and in 170 countries and territories around the world.

To find a provider in the U.S. visit blueshieldca.com/find-a-doctor or call (800) 810-2538.

To find a provider outside the U.S. visit blueshieldca.com/find-a-doctor and click "Search Outside U.S.". You can also call (800) 810-2583 or call collect from outside the U.S. at (804) 673-1177 for further assistance.

BLUE SHIELD WELLNESS



LEARN ABOUT PREVENTIVE CARE FOR YOU AND YOUR FAMILY

Seeing your doctor once a year for a preventive care visit can help you catch small problems before they turn into big ones. Find out what screenings, services, and immunizations we recommend for you and your family. Visit blueshieldca.com/preventive.

Make real improvements to your health with Wellvolution

Take charge of your health with Blue Shield's Wellvolution® program. Wellvolution is a digital platform for health and well-being. Tap into decades of research and leading technology for a more productive and healthier lifestyle. Wellvolution® provides online and in-person programs for those looking to improve their health and wellbeing. These programs are proven and backed by doctors' methods for results.

Wellvolution® offers the largest curated collection of scientifically-backed apps and programs – at no extra cost designed to help you:

- Prevent and reverse disease
- Manage stress
- Sleep better
- Eat healthier
- Move more
- Ditch cigarettes

To discover your proven path, visit Wellvolution.com.

Save on fitness club memberships & more

Get help saving money and living healthier with a wide range of wellness discount programs, including Fitness Your Way™. This program gives you access to thousands of gyms nationwide with no long-term contracts. Gym packages start at just \$19 per month as a one-time enrollment fee of \$19 (plus applicable taxes). The wellness discount programs also include acupuncture and chiropractic services; therapeutic massage; and eye exams, frames, contact lenses, and LASIK surgery. Learn more at blueshieldca.com.

CARRUM HEALTH BENEFITS

Click to play video



WHERE CAN I GET MORE INFO?

Carrum Surgery and Cancer:

Phone: 888-855-7806

Web: carrum.me/tutorperini

Mobile App: Search Carrum Health in the App Store or Google Play to download the app!

Galleri Testing:

Phone: 833-694-2553

Web: galleri.com/tutorperini

Members enrolled in a Blue Shield medical plan will have access to Carrum's Surgery Benefit, Cancer Care Program and Galleri Testing.

A surgery benefit that's hard to believe

Carrum Health is a unique benefit that provides access to some of the country's top surgeons and covers most, if not all, surgery costs for over 100 procedures. Please note, these benefits will be subject to the deductible on the HDHP plan. This means you can rest easy knowing you'll receive exceptional surgical care without large out-of-pocket expenses. That's why Tutor Perini is sponsoring Carrum Health as a voluntary benefit to all Blue Shield members. Carrum makes it easier, more enjoyable, and less expensive to get high-quality healthcare.

Covered surgeries include*:

- Knee
- Hip
- Elbow
- Oncology (Cancer Care)
- Spine
- Shoulder
- Cardiac (heart)
- Bariatric (weight loss)

*Some outpatient surgeries and procedures might not be covered by Carrum Health or may need to be reviewed. To find out about coverage, please call Carrum Health at 888-855-7806.

Carrum Cancer Care Program

When facing cancer, getting the correct diagnosis and accessing the latest research is critical for achieving the best possible outcome. The Carrum Cancer Care Program provides access to:

- Guidance and expertise from top cancer specialists for any form of cancer
- Treatments from leading cancer centers for breast, thyroid, and blood cancers
- Dedicated care navigator for complete coordination through your entire cancer journey
- And more!

Galleri Cancer Screening Test

The Galleri test gives you more control when it comes to cancer. Galleri is a multi-cancer early detection test, a blood test that screens for many of the deadliest cancers before they become symptomatic, including those without recommended screening tests. This benefit is offered to employees and dependents that are over the age of 50 or over the age of 40 with certain risk factors and enrolled in the Blue Shield PPO plan (not available on the HDHP plan).

NEW! VIRT DIABETES & WEIGHT MANAGEMENT



NO COST DIABETES & WEIGHT MANAGEMENT

The program is offered at no cost to employees through OptumRx when enrolled in a Blue Shield medical plan.

This benefit is effective 1/1/2026.

Take a look at Virta

Virta is a guided, online nutrition program that helps you lose weight, reverse type 2 diabetes, and feel better—at no additional cost to you. This personalized, flexible approach fits your lifestyle and shows you how to eat the foods that support real, lasting results.

This program includes:

- One-on-one support from a dedicated health coach and medical provider.
- Digital tools to track your progress and provide real-time insights.
- A simple, sustainable nutrition plan backed by science.

Is Virta right for me?

Virta takes a personal approach to care. This has helped members of diverse backgrounds, needs, and lifestyles find success. Virta is not a good fit if you:

- Are younger than 18 years old
- Are pregnant or nursing
- Have stage 4 or 5 chronic kidney disease
- Have end-stage renal disease on dialysis
- Had diabetic ketoacidosis in the past 12 months

Get your free starter kit

Your free starter kit includes:

- A digital weight scale
- Connected meter to monitor blood sugar
- Delicious recipes, and more

Visit go.virta.com/starterkit to claim your benefit.

How do I sign up?

Start your health journey in 3 easy steps:

1. **Create your account** – Visit go.virta.com/try and sign up with your email to get started.
2. **Answer basic health questions** – Understanding your health and lifestyle helps us meet your needs.
3. **Download the Virta app** - Message your care team, gain health insights, and start your personalized plan.

PRESCRIPTION DRUGS – OPTUMRX



OPTUMRX APP

You can also use the [OptumRx](#) app to search for providers. Download from the App Store or Google Play.

FORMULARY

OptumRx formulary will be updated effective January 1, 2026.

The formulary is the list of generic and brand name prescription drugs covered by the plan. Formularies are updated annually, this is to help keep the listing up-to-date when new drug becomes available, or when the FDA decides a drug is harmful. It also helps keep the cost of your medications down.

You can find a list of formulary and preventive medications on OptumRx's [Prescription Drug List](#) website. Search your medication(s) to confirm covered status or covered alternatives.

Our prescription drug plan is administered by [OptumRx](#). The prescription benefit is a stand-alone Plan and is not administered by Blue Shield. To refill your prescriptions, use your OptumRx prescription ID card, refill order forms, OptumRx website, or the toll-free member services telephone number 855-524-0381.

OPTUMRX PROGRAMS

VACCINATIONS AT RETAIL PHARMACIES

To help you stay healthy, you can receive vaccinations conveniently administered at your participating retail pharmacy through your prescription plan.

To locate a participating pharmacy, log in at optumrx.com and click *Prescriptions* then, *Find A Pharmacy*. Make sure the selected pharmacy is part of your participating network.

MAINTENANCE PROGRAM: MAIL SERVICE SAVER

You are required to refill maintenance medication for conditions such as cholesterol, high blood pressure, diabetes, or asthma, through the Mail Service Saver program. If you have not transferred your maintenance medication(s) to the Mail Service Saver program by your second refill, you will have to pay the mail order copay at the retail pharmacy on the third fill thereafter.

You can transfer medications to Select Home Delivery by calling OptumRx Home delivery at 855-524-0381.

CLINICAL BUNDLE – MEDICATION ADHERENCE

This program provides support to members to help take their medications as prescribed. OptumRx helps members stay on track with their health and medications. This program includes outreach to providers, letters to members, and phone call outreach to members. OptumRx will outreach to members who can benefit from this program.

MEDICAL PLANS

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

	BLUE SHIELD HDHP		BLUE SHIELD PPO	
	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Calendar Year Deductible²				
Individual	\$1,700	\$3,400	\$2,000	\$4,000
Individual in a family	\$3,400	\$6,800	\$2,000	\$4,000
Family	\$3,400	\$6,800	\$4,000	\$8,000
Embedded/Aggregate ³	Aggregate	Aggregate	Embedded	Embedded
Calendar Year Out-of-Pocket Maximum²				
Individual	\$4,300	\$7,600	\$4,000	\$7,500
Individual in a family	\$4,300	\$7,600	\$4,000	\$7,500
Family	\$8,600	\$15,200	\$8,000	\$15,000
Embedded ⁴	Embedded	Embedded	Embedded	Embedded
Office Visit				
Primary Care	Plan pays 80% *	Plan pays 50% *	\$25 copay	Plan pays 50% *
Specialist	Plan pays 80% *	Plan pays 50% *	\$40 copay	Plan pays 50% *
Online Visit (Teladoc)	Plan pays 100%	Not covered	\$10 copay per consult	Not covered
Preventive Services	Plan pays 100%	Plan pays 50% *	Plan pays 100%	Plan pays 50% *
Chiropractic (up to 20 visits/calendar year)	Plan pays 80% *	Plan pays 50% *	Plan pays 80% *	Plan pays 50% *
Lab and X-ray	Plan pays 80% *	Plan pays 50% *	Plan pays 80% *	Plan pays 50% *
Urgent Care	Plan pays 80% *	Plan pays 50% *	\$25 copay	Plan pays 50% *
Emergency Room	\$300 copay then plan pays 80% * (copay waived if admitted)		\$300 copay then plan pays 80% (copay waived if admitted)	
Inpatient Hospitalization	Plan pays 80% *	Plan pays 50% * (up to \$600/day)	\$300 admission copay then plan pays 80% *	\$500 admission copay then plan pays 50% * (up to \$1,500/day)
Outpatient Surgery	Plan pays 80% *	Plan pays 50% * (up to \$350/day)	Plan pays 80% *	Plan pays 50% * (up to \$600/day)
PRESCRIPTION DRUGS (OptumRx)				
Calendar Year Deductible	Medical Deductible Applies		None	
Out-of-Pocket Maximum	Medical Out-of-Pocket Maximum Applies		\$3,850 Individual / \$7,700 Family	
Retail- 30 Day Supply				
Generic	\$15 copay *	\$15 copay *	\$15 copay	\$15 copay
Brand Formulary ⁵	20% * (Min \$35, Max \$50)	20% * (Min \$35, Max \$50)	20% (Min \$35, Max \$50)	20% (Min \$35, Max \$50)
Brand Non-Formulary ⁵	20% * (Min \$60, Max \$100)	20% * (Min \$60, Max \$100)	20% (Min \$60, Max \$100)	20% (Min \$60, Max \$100)
Specialty	20% * (Max \$200)	20% * (Max \$200)	20% (Max \$200)	20% (Max \$200)
Mail Order- 90 Day Supply				
Generic	\$30 copay *	Not Covered	\$30 copay	Not Covered
Brand Formulary ⁵	20% * (Min \$70, Max \$100)	Not Covered	20% (Min \$70, Max \$100)	Not Covered
Brand Non-Formulary ⁵	20% * (Min \$120, Max \$200)	Not Covered	20% (Min \$120, Max \$200)	Not Covered
Specialty	20% * (Max \$400)	Not Covered	20% (Max \$400)	Not Covered

*Benefits with an asterisk require the deductible to be met first before the plan begins to pay.

¹When members use out-of-network providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar year deductible or copayment maximums.

²Deductibles and out-of-pocket maximums accumulate on a calendar year from JANUARY 1ST through DECEMBER 31ST.

³An aggregate deductible means your family must meet the entire family deductible before any individual expenses are covered. An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.

⁴An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum. All covered expenses including your medical deductibles accumulate towards the out-of-pocket maximum.

⁵Member pays the difference: If the member requests a brand name drug when a generic is available, the member pays the applicable copayment plus the difference in cost between generic and brand name drugs. This also applies when the physician selects "Dispense as Written" on the prescription. The difference in cost does not apply towards the out-of-pocket maximum

YOUR BENEFIT COSTS

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. 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
Blue Shield & OptumRx HDHP (Non-Tobacco)			
Employee Only	\$138.65	\$69.33	\$32.00
Employee + Spouse/DP	\$388.38	\$194.19	\$89.63
Employee + Children	\$339.36	\$169.68	\$78.31
Employee + Family	\$616.92	\$308.46	\$142.37
Blue Shield & OptumRx HDHP (Tobacco)			
Employee Only (Tobacco User)	\$370.28	\$185.14	\$85.45
Employee + Spouse/DP (One or More Tobacco User)	\$620.01	\$310.00	\$143.08
Employee + Children (One Tobacco User)	\$570.99	\$285.49	\$131.77
Employee + Family (One Tobacco User)	\$848.55	\$424.27	\$195.82
Blue Shield & OptumRx PPO (Non-Tobacco)			
Employee Only	\$154.26	\$77.13	\$35.60
Employee + Spouse/DP	\$425.58	\$212.79	\$98.21
Employee + Children	\$372.67	\$186.34	\$86.00
Employee + Family	\$672.71	\$336.35	\$155.24
Blue Shield & OptumRx PPO (Tobacco)			
Employee Only (Tobacco User)	\$385.89	\$192.95	\$89.05
Employee + Spouse/DP (One or More Tobacco User)	\$657.21	\$328.60	\$151.66
Employee + Children (One Tobacco User)	\$604.30	\$302.15	\$139.45
Employee + Family (One or More Tobacco User)	\$904.34	\$452.17	\$208.69

HEALTH SAVINGS ACCOUNT (HSA)

Click to play video



ARE YOU ELIGIBLE?

The HSA is not for everyone. You're eligible to contribute only if you are:

- Enrolled in the Blue Shield HDHP medical plan.
- Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
- Not someone else's tax dependent.
- Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

Note: If you are on the FSA option in 2025 and newly enrolling in the HDHP plan for 2026, you will not be able to contribute to your HSA account until your Grace Period runs out. However, if you have spent all of your FSA funds by the end of the 2025 plan year, you are able to begin contributing to your HSA at the start of the plan year.

A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future. This program is administered through [Health Equity](#).

How the Blue Shield HDHP + HSA works:

- Your HSA account is set up automatically after you enroll in the Blue Shield HDHP medical plan.
- You can contribute up to the 2026 annual limit set by the IRS:
Individual: \$4,400
Family: \$8,750
Are you age 55 or over? You can contribute an additional **\$1,000** per year in catch-up contributions
- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Five Reasons to Love an HSA:

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save it to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses, taxable but no penalties.
5. **Use funds for dependents.** As a note, the ACA requires medical plans to cover dependents to age 26; however, it does not require these dependents to be tax dependents. To use HSA funds for dependent expenses, the dependent must specifically be able to be claims as a dependent on the HSA owner's tax return.

Find out more

- [HealthEquity Website](#)
- [Eligible Expenses](#)
- [Ineligible Expenses](#)
- [The Easy Guide to Understanding Your HDHP and HSA](#)

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video



ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA. However, if you or your spouse are enrolled in a high-deductible health plan (like our Blue Shield HDHP plan) you can only participate in the **Limited Purpose FSA** for dental and vision expenses.

Find out more

- [HealthEquity Website](#)
- [HSA vs. FSA Flyer](#)
- [Eligible Expenses](#)
- [Ineligible Expenses](#)

Important Considerations

- Expenses must be incurred between **1/1/2026** and **3/15/2027**. Claims must be submitted for reimbursement no later than **4/30/2027**.
- There is a 2 ½ month extension period following the end of the plan year during which you may incur expenses and be reimbursed from the previous year's remaining balance. If you don't spend all the money in your account, you forfeit the leftover balance.
- Elections cannot be changed during the Plan year unless you have a qualified change in family status and the election change must be consistent with the event. You must re-enroll in this program each year.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their child(ren), unless they qualify as your tax dependent(s)

Set aside healthcare dollars for the coming year

A healthcare Flexible Spending Account (FSA) allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered through [Health Equity](#).

Healthcare FSA

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to **\$3,300** for the 2026 plan year. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Limited Purpose FSA

- If you/your spouse are enrolled in a high-deductible health plan (like our Blue Shield HDHP plan), you can only participate in the Limited Purpose FSA for dental and vision expenses.
- All other considerations listed above also apply to the Limited Purpose FSA.

Important: Questions about the tax status of your dependent(s) should be addressed with your tax advisor.

- You can also submit your eligible expenses for reimbursement via the HealthEquity app or online at healthequity.com.
- Keep your receipts. In most cases, you'll need to provide proof that your expenses were considered eligible for IRS purposes.
- If you are enrolling in the FSA program for 2026, debit cards will be mailed to you.

If substantiation documentation is requested, you must submit appropriate documentation, or your benefits card will be deactivated.

PAYING FOR DAYCARE? MAKE IT TAX-FREE!



EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Set aside up to \$5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by [Health Equity](#).

Dependent Care FSA

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you, consider your tax dependent and is physically or mentally incapable of self-care.

You can set aside up to **\$5,000** per household per year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.



Estimate carefully! You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

Important Considerations

- Expenses must be incurred between **1/1/2026** and **3/15/2027**. Claims must be submitted for reimbursement no later than **4/30/2026**.
- There is a 2 ½ month extension period following the end of the plan year during which you may incur expenses and be reimbursed from the previous year's remaining balance. If you don't spend all the money in your account, you forfeit the leftover balance.
- Elections cannot be changed during the Plan year unless you have a qualified change in family status and the election change must be consistent with the event. You must re-enroll in this program each year.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their child(ren), unless they qualify as your tax dependent(s)

Important: Questions about the tax status of your dependent(s) should be addressed with your tax advisor.

- You can also submit your eligible expenses for reimbursement via the HealthEquity app or online at healthequity.com.
- Keep your receipts, you'll need to provide proof that your expenses were considered eligible for IRS purposes.
- If substantiation documentation is requested, you must submit appropriate documentation, or your benefits card will be deactivated.

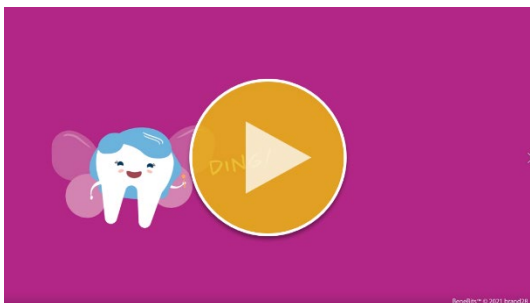


DENTAL

OUR PLAN

AETNA DENTAL PPO

Click to play video



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

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 (only available to dependent children up to age 20).

DENTAL

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

	Aetna Dental PPO		
	In-Network ¹		Out-of-Network ²
Calendar Year Deductible (Waived for Diagnostic and Preventive Services)	\$75 individual \$150 family		
Calendar Year Plan Maximum	\$1,500		
Diagnostic & Preventive Exams, X-rays & Cleanings	100%		100%
Basic Services Fillings, Root Canals & Periodontics	80%		80%
Major Services Crowns, Bridges & Implants	50%		50%
Orthodontia³ Children (up to age 20)	50% up to \$2,000 lifetime maximum		50% up to \$2,000 lifetime maximum
COST OF COVERAGE – Per Paycheck	Monthly	Semi-Monthly	Weekly
Employee Only	\$24.75	\$12.38	\$5.71
Employee + Spouse/DP	\$55.56	\$27.78	\$12.82
Employee + Child(ren)	\$54.89	\$27.45	\$12.67
Employee + Family	\$55.37	\$27.69	\$12.78

¹ Based on Aetna negotiated fee schedule

² Based on 80th percentile of usual, customary, and reasonable fee (this is defined as the charge for dental care that is consistent with the average rate or charge for identical or similar services in a certain geographical area. This Plan will exclude coverage amounts that are over the 80th percentile of usual, customary, and reasonable, leaving the amount over the 80th percentile to be the responsibility of the employee).

³ Orthodontia is covered only for children (appliance must be placed prior to age 20)

What you need to know about this plan?

Features:

Am I restricted to in-network providers?

See any provider, but you'll pay more out of network

No

Do I have to select a primary dentist?

No

Can I use my HSA or FSA?

If you participate in an HSA, Healthcare FSA or Limited Purpose FSA, you can use your account to pay for dental expenses.

Where can I get more details?

Visit the [Aetna Dental website](#) or app.



VISION

OUR PLAN

VSP CHOICE

We offer one vision plan through **VSP**.

Why Sign Up For Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK, rebates on contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

Click to play video



VISION

Our vision plan is administered by **VSP**. The VSP vision plan allows you to see any provider of choice; however, you will pay less out-of-pocket if you see a VSP contracted in-network provider.

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	VSP Choice		
	In-Network	Out-of-Network Reimbursement ¹	
Exams <i>Once every 12 months</i>	\$10 copay	Up to \$45	
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Standard Progressive <i>Once every 12 months</i>	\$25 copay \$25 copay \$25 copay Covered in full	Up to \$30 Up to \$50 Up to \$65 Up to \$50	
Frames² <i>Once every 24 months</i>	150 allowance + 20% off remaining balance	Up to \$70	
Contacts (Elective)³ Conventional Fitting & Evaluation <i>Once every 12 months</i>	\$150 allowance \$60 copay	Up to \$105 N/A	
COST OF COVERAGE – Per Paycheck	Monthly	Semi-Monthly	Weekly
Employee Only	\$6.24	\$3.12	\$1.44
Employee + 1	\$12.46	\$6.23	\$2.88
Employee + Child(ren)	\$13.31	\$6.66	\$3.07
Employee + Family	\$21.32	\$10.66	\$4.92

¹If you see an out-of-network provider you will be required to pay for the visit out-of-pocket and submit your claim for reimbursement based upon the out-of-network schedule.

²\$170 featured frame allowance and \$80 Costco allowance available

³Contacts lenses are in lieu of lenses and frames.

What you need to know about this plan?

Features:

What other services are covered?

See any provider, but you'll pay more out of network

Eyeglasses are expensive. Will I still be able to afford them, even with insurance?

The plan can also help you save money on LASIK procedures, sunglasses, computer glasses and more.

Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in an HSA, Healthcare FSA or Limited Purpose FSA, you can use your account to pay for vision care and eyewear with tax-free dollars.

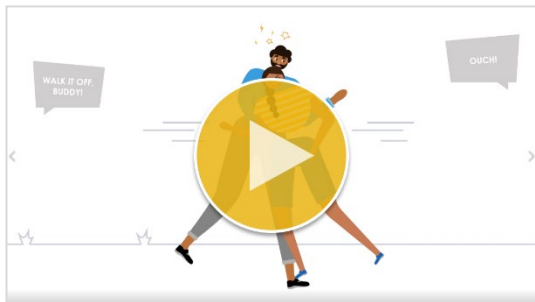
Where can I get more details?

Visit the [VSP website](#) or app.

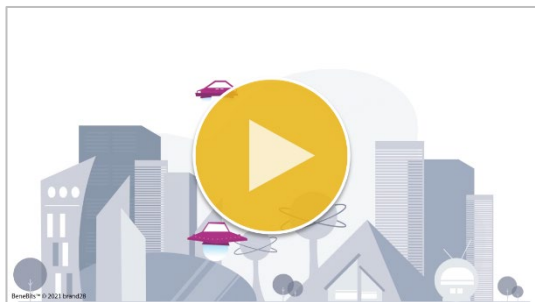


ENGAGE

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*

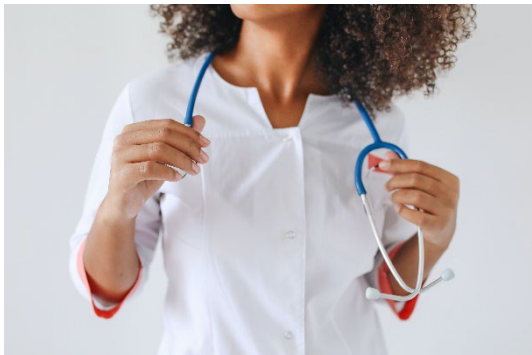
**in-network*

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.

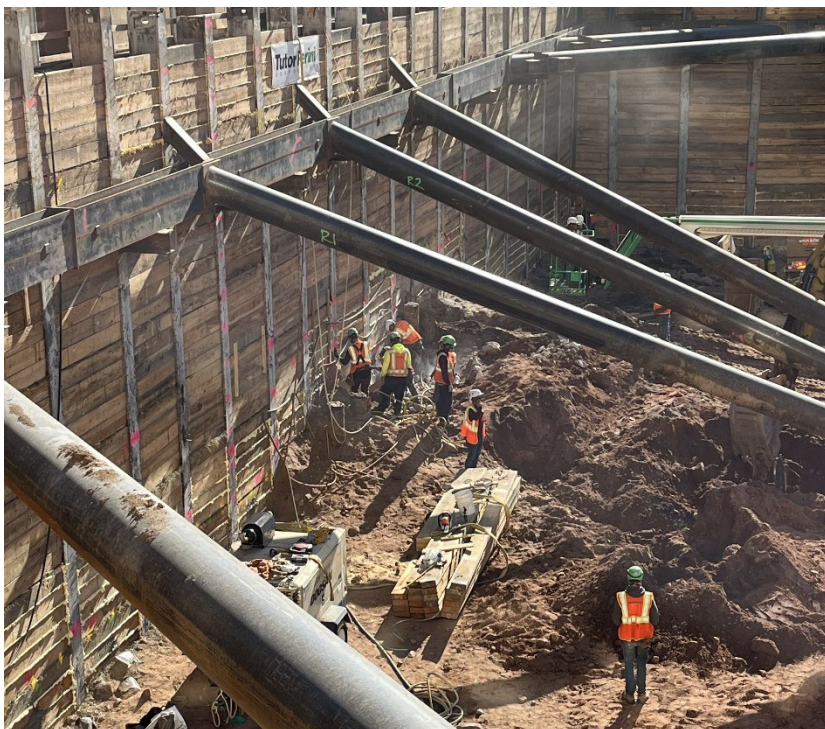
What is a formulary?

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.

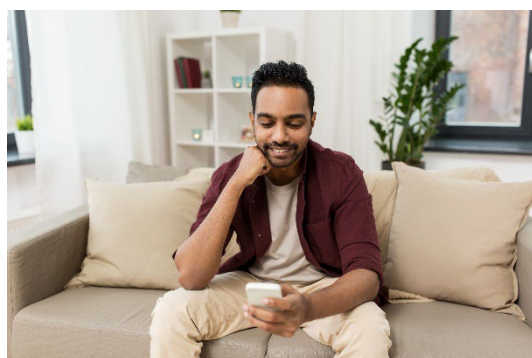
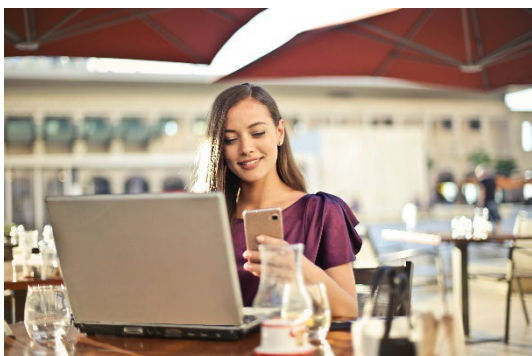
Get the most from your coverage

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!



- **BLUE SHIELD MEDICAL:** Blue Shield medical members can find a network provider, get estimates for most procedures, view your medical plan summary, view deductible and out of pocket amounts, search claims, and view ID cards.
 - **ACCOLADE:** Blue Shield members also have access to Accolade. You can get personalized benefits guidance, virtual care, and expert medical opinions from the Accolade app.
 - **TELADOC:** Blue Shield members also have access to Teladoc via the mobile app. Easily schedule virtual visits and meet with a provider within minutes.
 - **BLUE CROSS BLUE SHIELD GLOBAL CORE:** Blue Shield members can find providers, translate medical forms, access emergency info and more when traveling and needing access to care outside of the U.S.
- **OPTUMRX PRESCRIPTION DRUGS:** OptumRx members can compare drug costs, view and manage medications, check order statuses and view ID cards.
- **HEALTHEQUITY:** Members with an HSA or FSA accounts can download the HealthEquity app to log in and view accounts
- **AETNA DENTAL:** Aetna Dental members can find a network dentist, view plan summaries, use the treatment cost estimator, and view ID cards.
- **VSP:** VSP members can find network providers, get turn-by-turn directions from your locations, view vision benefits and find answers to common questions.
- **T. Rowe Price (401k):** Plan participants can view their account balance and get a snapshot of their retirement savings progress.
- **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 Variable Universal Life Coverage (GVUL) 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 GVUL 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 GVUL 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 GVUL 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 Variable 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.
- **Grief 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		GUARANTEE ISSUE MAXIMUM
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	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 GVUL coverage may also require EOI. MetLife will reach out and provide EOI forms when necessary.
	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 GVUL will work directly with MetLife.

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	7 days of disability
Sickness	7 days of disability
Maximum Payment Period¹	173 days

¹Maximum 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) $\$32,000 / 52 \text{ weeks} = \$615.38$ weekly earnings
- (2) $\$615.38 \times 60\% = \$369.23$ weekly benefit
- (3) $\$369.23 / \$10 = \$36.92$
- (4) $\$36.92 \times \$0.718 = \$26.51$ 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) $\$26.67 \times \$0.35 = \$9.33$ per month

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



VOLUNTARY PLANS

OUR VOLUNTARY PLANS

Accident

Hospital Indemnity

ID Theft

Legal

Pet Insurance

Voluntary Life Insurance with
Long-Term Care

You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

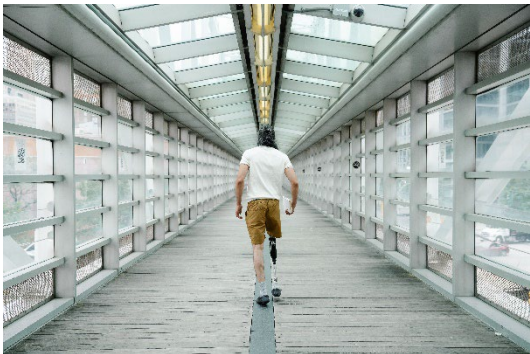
Tutor Perini offers plans to help:

- replace income if you're injured or ill
- bridge the gap for special healthcare needs
- secure your identity, and help you manage legal issues
- save money on protection for your pets

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.

VOLUNTARY HEALTH-RELATED PLANS



THINGS TO CONSIDER

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.

Accident Insurance

Accident Insurance from **UNUM** helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose.

	Monthly
Employee Only	\$5.54
Employee + Spouse	\$9.94
Employee + Children	\$13.17
Employee + Family	\$17.57

Hospital Indemnity Insurance

Hospital indemnity insurance from **UNUM** can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit, for paying medical bills, childcare, or for regular living expenses like groceries—you decide.

	Monthly
Employee Only	\$10.85
Employee + Spouse	\$23.50
Employee + Children	\$15.44
Employee + Family	\$28.09

PLANS TO KEEP YOU AND YOUR FAMILY SECURE



CONTACT INFORMATION

See the Plan Contacts section of this guide for contact information.

Identity Theft Protection

Identity theft is serious. Victims can spend hundreds, even thousands of dollars, and weeks of their own time to repair the damage done to their good names and credit records. The longer identity fraud goes undetected, the more expensive and difficult it becomes to resolve. For an affordable monthly premium, identity theft protection from **LifeLock** helps protect your personal information through proactive monitoring, identity restoration, and resolution.

	Monthly
Employee Only	\$8.49
Employee + Family	\$16.98

Legal Program

Do you have an attorney on retainer? Most people don't, so our legal program offers you access to legal advice and even representation for an affordable monthly premium. Whether you need assistance reviewing a rental agreement, fighting a traffic ticket, creating a will, buying a house or navigating an IRS audit, legal coverage from **MetLife Legal** offers reputable attorney assistance for you and your family. This Program costs \$18 per month.

Pet Insurance

Pets are members of the family too. When your pet gets sick, bills can add up faster than expected. Pet insurance prevents you from needing to weigh your pet's health against your bank account. Most plans offer coverage for costs associated with both accidents and illnesses—even medications. **Pets Best** provides coverage for this program.

Visit PetsBest.com/EBPerini to get started. The Pet Insurance will be billed to a credit card, debit card or ACH withdrawal at the frequency that you choose.

VOLUNTARY LIFE INSURANCE WITH LONG-TERM CARE (LTC)



EVIDENCE OF INSURABILITY

You may enroll without Evidence of Insurability (EOI) when you first become eligible (e.g., when you are hired or go from benefit ineligible to eligible status). EOI is required by CHUBB when you enroll in LTC outside of your initial enrollment period.

Using your Benefit

The LifeTime Benefit Term protects your family with money that can be used any way they choose. It is most often used to pay for mortgage or rent, education for children and grand children, retirement, family debt, and final expenses. Cash benefits can also be paid directly to you for long term care(LTC) expenses while you are living.

LTC is paid out at **4%** of your death benefit each month. Your death benefit will reduce proportionately each month as you receive benefit payments for LTC for up to **25 months**.

However, there is an additional 25 months with the **Extension of Benefits Rider** that is added on if 100% of the benefit is used for LTC, thus making it a **50-month** benefit. Across the 50-month period, you will have double the amount of the benefit you pick (see details on next page).

What is Long-Term Care?

Long-term care is the type of care received either at a nursing home or in an assisted living setting to assist with Activities of Daily Living (ADL's) due to an accident, illness or advancing age. Long-term care insurance pays benefits when a physician certifies that you are unable to perform two of six ADL's for a period that is expected to last at least 90 days. This benefit is available to employees and their family members. ADL's are: bathing, dressing, toileting, transferring, continence, and eating.

Coverage Amounts

Employee

Can pick a benefit amount ranging from \$5,000 to a maximum of \$225,000* from age 19-70 while those aged 71-80 can receive \$50,000*. Guaranteed issue during initial eligibility period is \$150,000.

Spouse

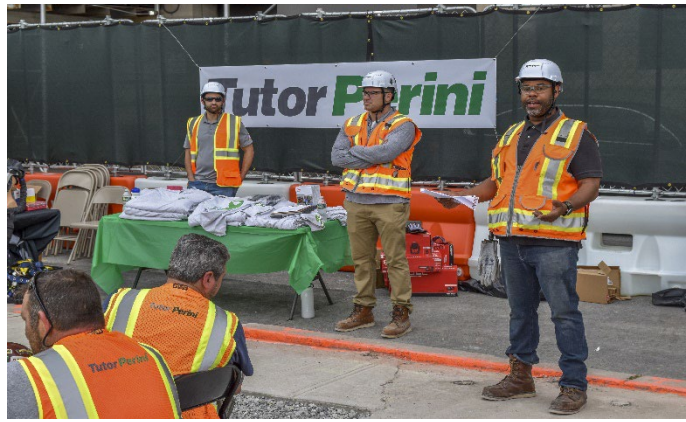
Can pick a benefit amount ranging from \$5,000 to a maximum of \$112,500* from age 19-70. Guaranteed issue during initial eligibility period is \$75,000.

Child(ren)

Can pick a benefit amount ranging from \$5,000 to a maximum of \$25,000 from 15 days to 25 years. This can be purchased as a rider for an additional cost.

*Subject to carrier approval

VOLUNTARY LIFE INSURANCE WITH LONG-TERM CARE (LTC)



Scenarios of how the benefit can adapt to your life circumstances

Below is a sample of how a \$100,000 benefit amount can be used.

Three Options	Life Situation	Death Benefit	LTC	LTC Extension	Total Benefit
1. Life Insurance	You lead a full life and do not need LTC	\$100,000	--	--	\$100,000
2. Long Term Care (LTC) Insurance	You lead a full life and need assisted living or nursing home care	--	\$100,000	--	
3. Split the Death Benefit for LTC and Life Insurance	You lead a full life but also need some LTC funds	\$52,000	\$48,000	--	
Additional Coverage for Long-Term Care					
Extra Long-Term Care option for up to 25 additional months	You lead a full life and need extended benefits for assisted living or nursing home care	--	--	\$100,000	\$100,00
Option 1, 2, or 3 + Extra LTC Coverage = TOTAL COVERAGE \$225,000 (For just LTC)					

If you would like additional information on this coverage, please follow the below link and complete the interest form to have a counselor reach out to you to answer your questions.

[Interest Form](#)

If you would like to enroll without speaking to a counselor, you can do so by following the below link:

[Enroll Now](#)

Your Login will be your SSN and your PIN is the last 4 digits of your SSN + last two of your birth year. Example: the last 4 of your SSN: 4343 and your birth year is 1987, your pin is 434387.



WELLBEING & BALANCE

THE KEY TO KEEPING YOUR BALANCE IS KNOWING WHEN YOU'VE LOST IT

The challenges of daily life can be hard to balance. Whether it's work, school or family obligations, it's no wonder that many of us sometimes have trouble managing the ups and downs of our day-to-day lives.

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, chemical dependency, mental health and family issues
- Maximize your physical well-being
- Take care of parenting/childcare, financial or legal needs

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

EMPLOYEE ASSISTANCE PROGRAM (EAP)



CONTACT THE EAP

Phone

866-248-4096

Website

www.liveandworkwell.com

Access Code: TUTOR

You also have access to additional resources through [Calm](#) and [Talkspace](#).

- The Calm app offers clinical techniques to help dial down the symptoms of stress, anxiety and depression. Visit LiveandWorkWell.com and select the Calm tile under the Benefits tab to download the Calm app.
- Support when you need it —no appointments necessary. With Talkspace, you can reach out to a licensed, in-network Employee Assistance Program Provider, 24/7. To get started, call your Employee Assistance Program at 866-248-4096 to obtain an authorization code prior to registering (first visit only), choose a provider, and message anywhere, anytime. Visit talkspace.com/connect for more information.

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through [Optum](#) can help you handle a wide variety of personal issue such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 8 session per issue per year
- Unlimited web access to helpful articles, resources, and self-assessment tools

COUNSELING BENEFITS

- Difficulty with relationship
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

PARENTING & CHILDCARE

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

FINANCIAL COACHING

- Money management
- Debt management
- Identity theft resolution
- Tax issues

LEGAL CONSULTATION

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

ELDERCARE RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

MENTAL HEALTH RESOURCES

These are challenging times, and we understand that you or people close to you may also be faced with additional work and family stresses. Feelings of isolation, depression or despair should never be taken lightly. This is a reminder that our medical plans include coverage for mental health care. And through our telemedicine provider, you can connect to a mental health provider within minutes, from any location, at any time.

	In-Network Mental Health Services	
	Outpatient	Inpatient
Blue Shield HDHP	20% after deductible (office visit) 20% after deductible (most other services)	20% after deductible
Blue Shield PPO	\$25 copay (office visit) No charge after deductible (most other services)	\$300 copay/admission + 20% after deductible

Blue Shield Resources through Wellvolution & Headspace Care (formerly Ginger)

You also have additional mental health support through Blue Shield's [Wellvolution](#) platform via the Headspace Care app which provides easy access to care - no matter where you are, when you need it, or what you're going through. Headspace Care offers on-demand, confidential mental healthcare through coaching and self-guided activities. Need to chat on the weekend? or at 3am on a holiday? Headspace Care is around 24/7/365. Headspace Care goes where your smartphone goes. Click [here](#) for more information

Mental Health Services through Teladoc Mental Health

Sometimes the hardest part about addressing a mental health issue is taking the first step. Now it's a bit easier through our telemedicine services from [Teladoc Mental Health](#). You can schedule an immediate video or phone consult with a provider anywhere, any time. To learn more and set up your account, go to [Teladoc.com](https://www.teladoc.com).

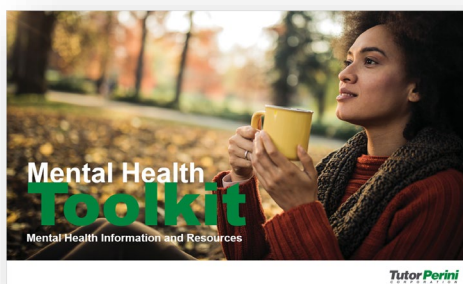
The EAP is always here to help!

If you're dealing with a little stress and anxiety or a lot; a relationship or substance abuse issue; financial worries; or the responsibility of caring for others; the Employee Assistance Program from Optum can help. Call 866-248-4096 or visit www.liveandworkwell.com.

Mental Health Toolkit

Interested in more information on mental health and the resources mentioned above?

Click the image below to view Tutor Perini Corporation's Mental Health Toolkit.





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



[amspremier.com](https://www.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.

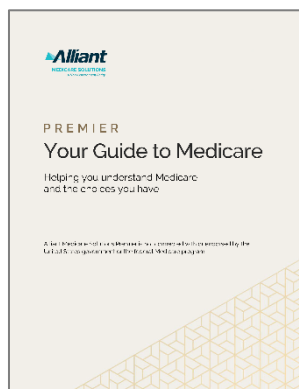
Alliant Medicare Solutions Premier

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.

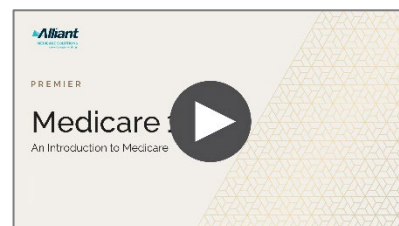
How it works

- 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](#)

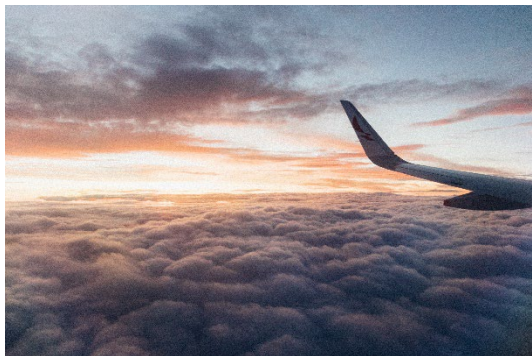


[Medicare 101](#)



[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?

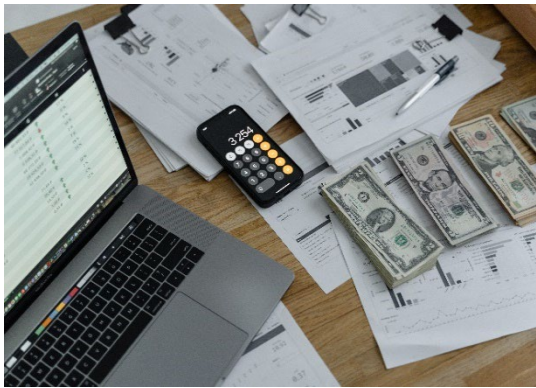
It is your responsibility to follow the normal Tutor Perini absence reporting procedures and notify your department head or manager of your absence.



FINANCIAL WELLNESS

PLANS TO HELP YOU SAVE

401(k) Retirement Savings Plan



Is it time for a “financial wellness” checkup?

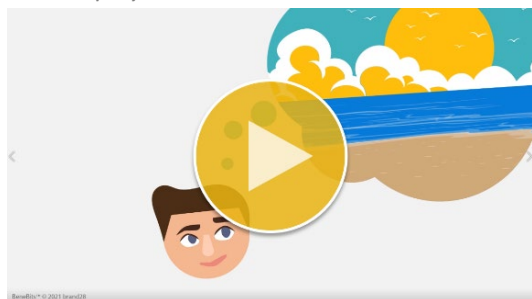
Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? And can you even think about preparing for retirement?

Ignoring your financial health can take a toll on your quality of life today and block opportunities for the future. And worrying about money matters can make you stressed, even to the point of physical illness.

We offer benefits and resources to help you make the most of your money now and in the future. You can increase your take-home pay by saving on taxes and work toward your retirement goals.

SAVE NOW, ENJOY LATER

Click to play video



WHAT ARE YOUR PLANS?

Many of us can't plan past the weekend, never mind thinking about a retirement nest egg. Our 401(k) retirement plan will help you set a retirement savings goal and stick to it.

The important thing is to start now and set aside what you can, even if you think it's too small an amount.

401(k) Retirement Savings Plan—up to \$23,500 per year (or more)

All team members have access to a 401(k) plan where you can select deferrals on a pre-tax or post-tax basis. Your 401k Benefit is offered through **T. Rowe Price**.

Visit the **T. Rowe Price** website at RPS.TRowePrice.com to manage your account, investments and contributions.

T. Rowe Price offers a variety of quality investment options. You'll also have access to special services such as automatic account rebalancing and personal investment assistance from a licensed investment counselor.

Maximum annual contribution limit

Up to **\$23,500** per year. IRS limits are evaluated annually and may change.

Catch up contributions

If you're age 50, save an additional **\$7,500** per year. IRS limits are evaluated annually and may change.

Tutor Perini matching contributions

Tutor Perini will match 100% of the first 3% that you set aside, and 50% of contributions exceeding 3%, not to exceed 5% of your eligible pay. Please see the Summary Plan Description for details on when you are vested in (own) contributions from Tutor Perini.

WHAT IS A CATCH-UP CONTRIBUTION?

A catch-up contribution is a type of retirement savings contribution that allows employees age 50 or older to make additional contributions to their 401K account. You can make catch-up contributions at any time during the calendar year in which you will turn 50. The catch-up option is a great way to save additional dollars as you approach retirement.

You can elect Catch-up contributions one of two ways.

1. Call T. Rowe Price and speak with a retirement specialists at 1-800-922-9945.
2. Log into the website at RPS.TRowePrice.com and follow the steps below:
 - a. Click on **TAKE ACTION** and then click on *Change Your Contributions*.
 - b. Check the box for Roth Catch-up or Catch-up and click on the *Next* button.

(If you want to learn more about Roth contributions or Catch-up contributions, click on Learn More highlighted in blue.)
 - a. Enter in the percentage under New Amount and click on *Next*.
 - b. Verify that the percentage you want is correct and click on *Submit* and you are done.

If you have any questions regarding your Retirement plan, please contact T. Rowe Price.

Phone: 800-922-9945

Website: RPS.TRowePrice.com



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.
Medical (HDHP & PPO)	Blue Shield of CA	Blue Shield of California P.O. Box 272540 Chico, CA 95927-2540	866-336-0791 Phone and Messaging: 8:00AM-11:00PM EST M-F CA: BlueShieldCA.com Non-CA: BCBS.com	W0051664
Prescription Drugs	OptumRx	OptumRx P.O. Box 650334 Dallas, TX 75265-0334	855-524-0381 24 hours/day; 7 days/week OptumRx.com	TUTOR
Virta Diabetes & Weight Management Program	OptumRx	N/A	go.virta.com/try	N/A
Dental	Aetna	Aetna Dental P.O. Box 14094 Lexington, KY 40512-4094	877-238-6200 8am-6pm Aetna.com	887067
Vision	Vision Services Plan (VSP)	Online Claim Reimbursement & Claim Reimbursement Form download, available at VSP.com	800-877-7195 VSP.com	30043329
HSA & FSA Administrator	HealthEquity	Claims Administrator P.O. Box 14053, Lexington, KY, 40512	HSA: 866-346-5800 FSA: 877-924-3967 healthequity.com	Tutor Perini
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 standard.com	166454
Employee Assistance Program	Optum	N/A	866-248-4096 24 hours/day; 7 days/week liveandworkwell.com	Code: TUTOR
Voluntary Surgery Benefit, Cancer Program, and Galleri Testing	Carrum Health Galleri	N/A	888-855-7806 carrum.me/tutorperini 833-694-2553 galleri.com/tutorperini	N/A
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.

PLAN CONTACTS (CONT.)

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

Plan Type	Provider	Claim Office	Member Services	Policy No.
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
Voluntary Group Legal Plan	MetLife Legal	Hyatt Legal Plans 1111 Superior Ave. Cleveland, OH 44114	800-821-6400 LegalPlans.com	6090522
Group Variable Universal Life Plan	MetLife	Please contact Human Resources	800-756-0124 8am-8pm (EST) M-F Enrollment Website: mybenefits.metlife.com	Tutor Perini
Voluntary Pet Insurance	Pets Best	Pets Best Claims 2710 Sunrise Rim Road, #100 Boise, ID 83705	T: 877-738-7237 ext. 1 F: 866-777-1434 E: claims@petsbest.com PetsBest.com/EBPerini	EBPerini
Accident and Hospital Indemnity	Unum	Unum.com/Claims	800-635-5597	Accident: 580533 Hospital Indemnity: 580534
Identity Theft Program	LifeLock Benefit Solutions	LifeLock Benefit Solutions 60 East Rio Salado Parkway, Suite 400 Tempe, AZ 85281	800-607-9174 9am – 7pm EST LifeLock.com	E0000176
Voluntary Life Insurance with Long-Term Care (LTC)	CHUBB	N/A	*855-241-9891 8:30 am – 7pm EST M-F csmail@gotoservice.chubb.com *contact information for current policyholders only – questions, changes, and cancellations	N/A
401(k)	T. Rowe Price	N/A	800-922-9945 RPS.TRowePrice.com	N/A
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

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 under age

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.

- **Blue Shield HDHP**
- **Blue Shield 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 Blue Shield HDHP and 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 Blue Shield HDHP and 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](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 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](https://www.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 Blue Shield 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.

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: KIHIPPROGRAM@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.medicicaid.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: HSHSHIPProgram@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 HIPPI 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-medicare-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 Rlte 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 (HIPPI) 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 (HIPPI) 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.

Illinois Consumer Coverage Disclosure Act

The Consumer Coverage Disclosure Act requires employers to notify Illinois employees which of the Essential Health Benefits listed below are and are not covered by their employer-provided group health insurance coverage. Refer to the [Access to Care and Treatment Benchmark Plan](#) and the [Pediatric Dental Plan](#) to reference the pages listed below.

Employer Name:		Tutor Perini Corporation		
Employer State of Situs:		California		
Name of Issuer:		Blue Shield of California		
Plan Marketing Name:		Tutor Perini Health & Welfare Plan		
Plan Year:		2026		
Ten (10) Essential Health Benefit (EHB) Categories:				
• Ambulatory patient services (outpatient care you get without being admitted to a hospital) • Emergency services • Hospitalization (like surgery and overnight stays) • Laboratory services • Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy) • Pediatric services, including oral and vision care (but adult dental and vision coverage aren’t essential health benefits) • Pregnancy, maternity, and newborn care (both before and after birth) • Prescription drugs • Preventive and wellness services and chronic disease management • Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)				
2023 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Yes
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Coverage is for the diagnosis and treatment of the underlying medical condition only.
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes, partially. Private Duty Nursing is only covered as part of an authorized hospice program.
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes

15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes, partially. Benefits do not include transportation and lodging.
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No. Covered under a separate dental plan if purchased.
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	No. Covered under a separate vision plan if purchased.
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes, partially. Benefits are limited to a per Member per Calendar Year visit maximum.
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

