KenCrest

Your Dreams. Our Mission.

2022 BENEFITS GUIDE

Welcome

At KenCrest Services, we appreciate your commitment and contributions to our company's success.

Each year, we strive to offer benefit plans to our employees that not only reward you for your hard work but offer you and your family comprehensive and affordable health and wellness protection. We are confident you will find our benefit offerings to be of excellent value to you and to your dependents.

In the following pages, you will find a summary of our benefit plans for July 1 through June 30. Please read this guidebook carefully as you prepare to make your elections for the Plan Year to ensure you select the coverage that is right for you.

In the following pages, you will find a summary of our benefit plans as of July 2022.

Table of Contents

In the following pages, you will find a summary of our benefit plans for the 2022-2023 plan year. For more detailed plan information, please refer to the plan documents.

If there is any discrepancy between the descriptions of the program's elements as contained in this benefits guidebook and the official plan documents, the language in the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. You should be aware that any and all elements of KenCrest Services' benefits program may be modified in the future, at any time, to meet Internal Revenue Service (IRS) rules, or otherwise as decided by KenCrest Services.

Program Elements & Rules

PLAN YEAR

The Plan Year for KenCrest Services' benefit programs begins on July 1 and ends on June 30.

ELIGIBILITY

All full time and part time employees who are regularly scheduled to work at least 20 hours per week are eligible to participate. Full-time employees working at least 30 hours per week are eligible for KenCrest contributions toward some of the benefit plan options. Eligibility begins the first day of the month following completion of the initial 60 day waiting period.

Dependent Eligibility

Employees who are eligible to participate in KenCrest Services' benefit programs may also enroll their dependents. For the purpose of our benefit plans, your dependents are defined as follows:

- Your legal spouse or domestic partner (special rules apply for domestic partner coverage).
- Dependent "Child(ren)" for medical and dental are defined as married or unmarried and includes natural; foster, including any children placed with you for adoption; stepchildren; legally adopted; responsible under court order; grandchildren in your court-ordered custody; and any other child with whom you have a parent-child relationship. They do not need to reside with you to be eligible for medical or dental coverage.
- Your unmarried children of any age who are mentally or physically disabled and totally dependent upon you for support (proof of condition and dependence must be submitted).
- For medical and dental, your children are covered to the end of the calendar month when they reach age 26. For Voluntary Life—children are covered to age 24 (must be unmarried; and solely dependent on your support).

Program Elements & Rules

MAKING CHANGES TO YOUR BENEFITS

Per Internal Revenue Service (IRS) rules, employees may only enroll in benefit plans once per year. As such, your benefit choices are binding through June 30. The following Qualifying Life Events are special circumstances that enable you to change your benefits during the plan year:

- Marriage
- Birth, adoption or placement for adoption of an eligible child
- Divorce, legal separation or annulment of marriage
- Loss of spouse's job or change in work status (when coverage is maintained through spouse's plan)
- A significant change in your or your spouse's health coverage due to your spouse's employment
- Death of spouse or dependent
- Loss of dependent status
- Employer-directed transfers to facilities out of the benefits network
- Becoming eligible for Medicare or Medicaid during the plan year
- Receiving a Qualified Medical Child Support Order

For any qualifying life events, you must complete the life event form in DayForce within 30 calendar days (60 calendar days for changes related to Medicaid or CHIP eligibility) and upload proof of the event. Changes due to a "change of mind" are not allowed until the next annual enrollment period. For additional information, please contact Human Resources.

Medical & Prescription Benefits Overview

KenCrest offers five comprehensive medical / prescription drug plan options through Aetna: Two Qualified High Deductible Health Plans (HDHP), two POS plans, and a version of an HMO plan which serves as an open access In-Network only plan.

Employees working over 20 hours per week are eligible to participate in one of KenCrest's medical programs. However, full-time employees working 30 or more hours per week are eligible for a contribution from KenCrest toward the cost of the coverage.

AETNA CHOICE POS HDHP

The Aetna HDHPs offer you direct access to any Aetna Choice POS II provider for covered services. Each time you or a covered dependent seeks care from a participating provider, you receive the highest level of benefits. You may also choose to seek treatment from a non-network provider; however, your out-of-pocket costs will be higher.

- If you enroll in the HDHP 3000 plan, KenCrest will automatically enroll you in a Health Savings Account (HSA).
- If you enroll in the HDHP 2000 plan, KenCrest will not automatically enroll you in a Health Savings Account but you can open an HSA using your designated payroll contributions.

The HDHPs do not require a Primary Care Physician Selection (PCP), nor do they require referrals to see any specialists.

The HDHPs include Aetna's Choice POS II network, which is national; as long as the provider participates with Aetna, you are covered in-network.

Some things to keep in mind about an HDHP:

- You pay the cost of the medical and pharmacy (unless on the preventive list) expenses until you meet your annual deductible. You can use your HSA funds to pay for these expenses or pay out of pocket and allow your HSA funds to grow for future use.
- HSA funding aligns with the benefit plan year of 7/1–6/30.
- After meeting your annual deductible, Aetna will pay 100% on the 2000 plan and 80% on the 3000 plan of your medical expenses thereafter. For prescription drugs, once you meet the deductible, you will pay the applicable copay. Deductible expenses and additional prescription drug copay expenses will apply toward the out-of-pocket maximum. Once you meet the out-of-pocket maximum, both plans cover all services at 100%.
- Plan deductible starts at zero on the first day of the plan year, July 1.
- If you cover yourself and your eligible dependents, under the HDHP 3000, no single individual within the family will be subject to more than the individual deductible. Under the HDHP 2000, you and your covered dependents must meet the entire family deductible before benefits are payable. Under both HDHPs, the family out-of-pocket maximum (payment limit) is cumulative for all family members; however, no single individual within the family will pay more than the individual out-of-pocket maximum.

Medical & Prescription Benefits Overview

AETNA HMO (Select In-Network Only Plan)

You can see your PCP for covered services as often as needed (you do not need to name a PCP, just use a network PCP); No referral is needed to seek care from a specialist. The Aetna HMO plan has a $250 per member/$500 max per family deductible that applies to all brand medications

If you are traveling outside of this area, you will have emergency coverage only, regardless of whether the provider/facility/pharmacy participates with the local Aetna network.

The Aetna HMO Select In-Network plan does not have out of network coverage for non-emergency services. If you seek treatment with a non- participating provider, facility or pharmacy, you will be responsible for the full cost of the services.

AETNA POS

Aetna's Choice POS plans are open access plans and do not require referrals. The Aetna Choice POS plans have a $250 per member/$500 max per family deductible that applies to all brand medications.

Aetna's Choice POS II plans includes out of network coverage should you need to seek treatment / services from a provider that is not local, or does not participate in the Aetna Choice POS II network. You will pay more out of pocket for out of network services.

Medical Benefits

PREVENTIVE CARE

All Aetna plans cover preventive care at 100% for in-network services. The member's financial responsibility would be limited to any non- preventive services you may receive during the visit. The plans cover services including colorectal cancer screenings, high blood pressure screenings, annual physicals, immunizations, mammograms, pap smears and osteoporosis screenings (age and frequency limitations may apply).

In addition, the plans cover the following women's health services at 100% when provided in-network:

- Well-women visits (annually including pre-natal)
- Screenings for gestational diabetes
- Screening for human papilloma virus (HPV)
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Contraceptive methods and counseling

Exceptions: The plans do not consider services on our preventive services list as preventive if a member receives them as part of a visit to diagnose, monitor or treat an illness or injury. In these instances, member cost sharing applies. Network providers should not bill members for preventive services that they deliver as part of preventive care. If this occurs, Aetna advises members to inform the provider that the plans cover these services at 100%.

CVS HEALTHHUB

HealthHUB is available at select CVS Pharmacy locations and provides access to health services and wellness products, all in one place. Some of the services available at HealthHUB locations are:

- Primary acute care
- Assistance with diabetes and other conditions
- 12+ immunizations
- Preventive care and wellness

Talk to our care concierge today or visit CVS.com/HealthHUB for more info!

Medical Benefits

TELADOC PROVIDED BY AETNA

Since July 1, 2017, KenCrest has been offering services by Teladoc. Some of the main features and benefits of Teladoc include:

- Simple way to access qualified doctors who are U.S. board- certified, credentialed and licensed in your state (such as PCPs, pediatricians, and family medicine physicians).
- Treatment for medical conditions (such as cold & flu symptoms, allergies, sinus problems, sore throat, respiratory infection, skin problems, and more).
- Call when you need care now; if you are considering the ER or urgent care for a non-emergency issue, on vacation, on a business trip, away from home, or for short-term prescription refills.
- Mobile App gives you simple and convenient access to a doctor in 10 minutes or less.
- Applicable primary care copay or employee cost share will apply based on the Aetna medical plan you have elected up to a $40 limit per event.

Once you are set up, a Teladoc doctor is always just a click away at www.Teladoc.com/Aetna or by calling 855-TELADOC (835-2362).

Prescription Benefits

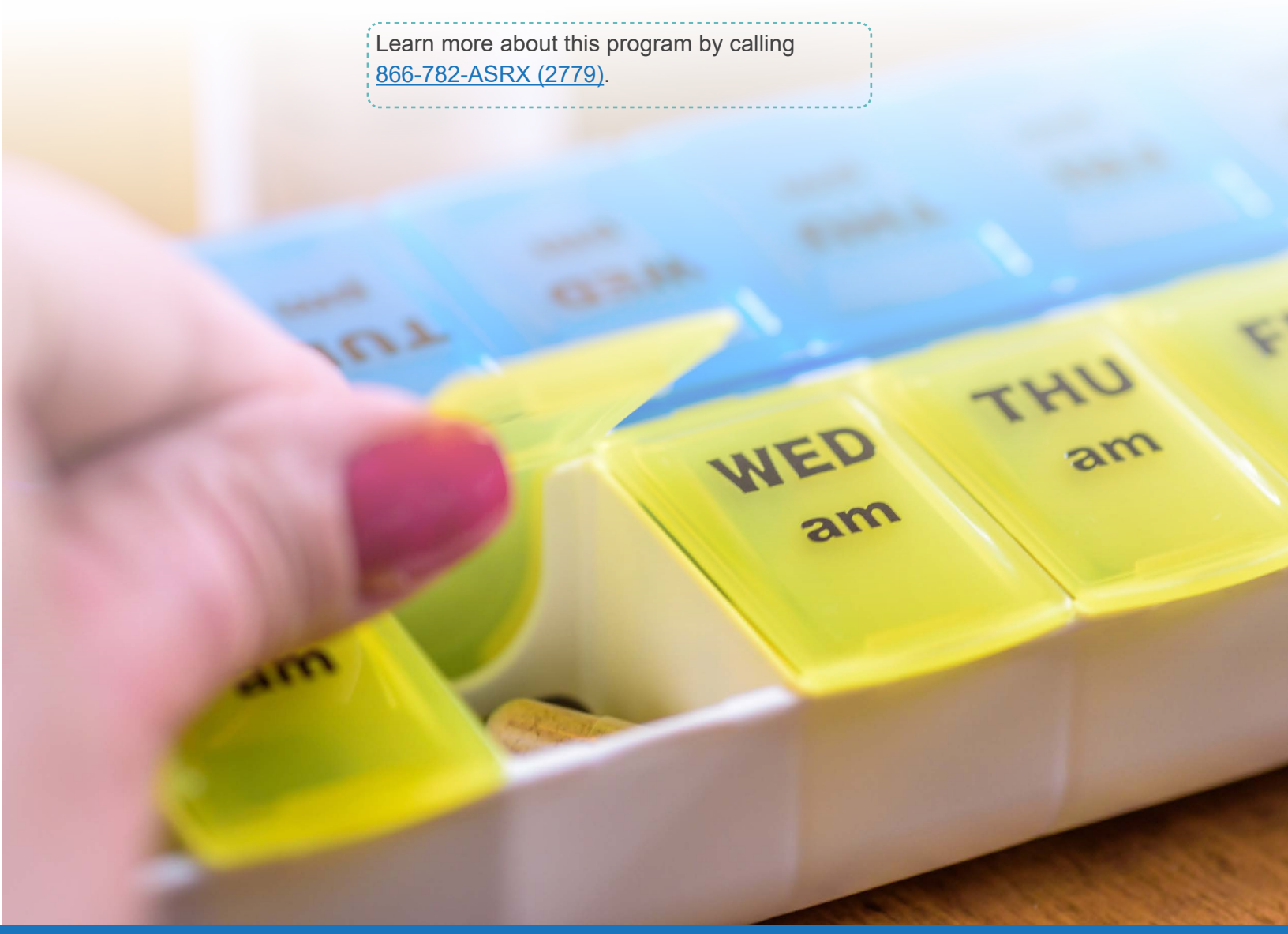
MANDATORY MAINTENANCE CHOICE WITH OPT-OUT

After two retail fills, the plans require you to fill a 90-day supply of Maintenance drugs at Aetna Rx Home Delivery® or CVS pharmacy. The member must notify Aetna of whether they want to continue to fill at a network retail pharmacy by calling the number on the member ID card. Otherwise, you and your covered dependents will be responsible for 100% of the cost-share.

STANDARD SPECIALTY PRESCRIPTIONS

Members must fill all specialty prescriptions through Aetna's Specialty Pharmacy. Specialty drugs treat complex, chronic conditions (examples are Enbrel and Humira). These drugs may be injected, infused or taken by mouth. You may need to refrigerate them. They are often expensive and may not be available at retail pharmacies. A nurse or pharmacist may monitor you during your treatment, if needed. Aetna Specialty Pharmacy provides services that include personal support, helpful resources and training, and free secure home delivery.

Learn more about this program by calling 866-782-ASRX (2779).



Medical & Prescription Plan Options

	AETNA CHOICE POS HDHP 2000		AETNA CHOICE POS HDHP 3000*	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible	Individual: $2,000 Family: $4,000	Individual: $5,000 Family: $10,000	Individual: $3,000 Family: $6,000	Individual: $5,000 Family: $10,000
Out-of-Pocket Maximum	Individual: $5,600 Family: $11,200	Individual: $10,000 Family: $20,000	Individual: $5,600 Family: $11,200	Individual: $10,000 Family: $20,000
PCP Selection Required?	No	No	No	No
Referrals Required?	No	No	No	No
Coinsurance applies after deductible is satisfied				
Primary Care Office Visit (PCP)	0% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Specialist Office Visit	0% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Nutritional Counseling (up to 10 visits per year)	0% coinsurance, no deductible applies	Not covered	0% coinsurance, no deductible applies	Not covered
Diagnostics (x-ray, blood work)	0% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Urgent Care	0% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Emergency Room	0% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Inpatient Hospital Stay	0% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Outpatient Surgery	0% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Routine Vision Exam	100% covered, no deductible	Not covered	100% covered, no deductible	Not covered
Vision Reimbursement	$100 every 24 months, no deductible	$100 every 24 months, no deductible	$100 every 24 months, no deductible	$100 every 24 months, no deductible

*Participants in the HDHP 3000 will receive $100 per month deposited into the HSA.

This chart is a summary of select benefit options offered under KenCrest Services' medical plans. For more information, please refer to the plan documents. KenCrest Services' medical plans are written under a Pennsylvania contract; therefore, other states' mandated laws do not apply to coverage. In the event of a discrepancy between this summary and the plan documents, the plan documents will govern.

Medical & Prescription Plan Options

PRESCRIPTION DRUG COVERAGE*

	AETNA CHOICE POS HDHP 2000		AETNA CHOICE POS HDHP 3000*	
Retail (30-day supply)				
Generic Formulary	$20 after deductible	50% of submitted cost after deductible	$20 after deductible	50% of submitted cost after deductible
Brand Formulary	$40 after deductible		$40 after deductible	
Brand Non-Formulary	$70 after deductible		$70 after deductible	
Mail Order (90-day supply)				
Generic Formulary	$40 after deductible	Not covered	$40 after deductible	Not covered
Brand Formulary	$80 after deductible		$80 after deductible	
Brand Non-Formulary	$140 after deductible		$140 after deductible	

MEDICAL AND PRESCRIPTION DRUG COVERAGE: MONTHLY PLAN DEDUCTIONS

	Part Time Cost	Full Time Cost	Part Time Cost*	Full Time Cost*
Single	$840.00	$120.00	$720.00	$0.00
Employee & Spouse	$1,757.53	$1,037.53	$1,452.72	$694.87
Employee & Child(ren)	$1,394.12	$674.12	$1,153.52	$417.34
Employee & Family	$2,222.11	$1,502.11	$1,823.86	$1,022.72

*You can also obtain a 90 day supply of medications for two copays at CVS/Target. This only applies to CVS/Target locations. Should you go to any other network pharmacy, you will pay three copays.

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Medical & Prescription Plan Options

	AETNA CHOICE HMO 40 PLAN	AETNA CHOICE POS 25 PLAN		AETNA CHOICE POS 15 PLAN	
	In-Network*	In-Network*	Out-of-Network	In-Network*	Out-of-Network
Annual Medical Deductible	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $1,500 Family: $4,500	Individual: $0 Family: $0	Individual: $1,500 Family: $4,500
Annual Prescription Deductible	Individual: $250 Family: $500	Individual: $250 Family: $500	Individual: $250 Family: $500	Individual: $250 Family: $500	Individual: $250 Family: $500
Out-of-Pocket Maximum	Individual: $3,000 Family: $6,000	Individual: $3,000 Family: $6,000	Individual: $10,000 Family: $30,000	Individual: $3,000 Family: $6,000	Individual: $10,000 Family: $30,000
PCP Selection Required?	No	No	No	No	No
Referrals Required?	No	No	No	No	No
Coinsurance applies after deductible is satisfied					
Primary Care Office Visit (PCP)	$40 copay	$25 copay	50% coinsurance	$15 copay	50% coinsurance
Specialist Office Visit	$50 copay	$40 copay	50% coinsurance	$35 copay	50% coinsurance
Nutritional Counseling (up to 10 visits per year)	0% coinsurance	0% coinsurance	Not covered	0% coinsurance	Not covered
Diagnostics (x-ray, blood work)	Lab: No charge X-ray: $50 copay	Lab: No charge X-ray: $40 copay	50% coinsurance	Lab: No charge X-ray: $35 copay	50% coinsurance
Imaging (CT/PET scans, MRIs)	$100 copay	$80 copay	50% coinsurance	$70 copay	50% coinsurance
Urgent Care	$85 copay	$70 copay	50% coinsurance	$50 copay	50% coinsurance
Emergency Room	$200 copay	$200 copay	$200 copay	$100 copay	$100 copay
Inpatient Hospital Stay*	$1,500 per stay	$1,500 per stay	50% coinsurance	$500 per stay	50% coinsurance
Outpatient Surgery	$500 copay	$250 copay	50% coinsurance	$250 copay	50% coinsurance
Routine Vision Exam	$0 copay every 2 years	$0 copay every 2 years	Not covered	$0 copay every 2 years	Not covered

*KenCrest will reimburse the in-network inpatient hospital stays copay up to $1,500 for anyone enrolled in the HMO 40, POS 25, or POS 15 plan.

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Medical & Prescription Plan Options

New for 7/1/2022
In-Network Rx Deductible: **$250** deductible for individual member
$500 maximum deductible per family
(Brand Name Only medications)

PRESCRIPTION DRUG COVERAGE*

	AETNA CHOICE HMO 40 PLAN	AETNA CHOICE POS 25 PLAN		AETNA CHOICE POS 15 PLAN	
	In-Network*	In-Network*	Out-of-Network	In-Network*	Out-of-Network
Retail (30-day supply)					
Generic Formulary	$20	$20	50% of submitted cost after deductible	$20	30% of submitted cost after deductible
Brand Formulary	$40 after Rx deductible	$40 after Rx deductible		$40 after Rx deductible	
Brand Non-Formulary	$70 after Rx deductible	$70 after Rx deductible		$70 after Rx deductible	
Mail Order (90-day supply)					
Generic Formulary	$40	$40	Not covered	$40	Not covered
Brand Formulary	$80 after Rx deductible	$80 after deductible		$80 after Rx deductible	
Brand Non-Formulary	$140 after Rx deductible	$140 after deductible		$140 after Rx deductible	

MEDICAL AND PRESCRIPTION DRUG COVERAGE: MONTHLY PLAN DEDUCTIONS

	Part Time Cost	Full Time Cost	Part Time Cost	Full Time Cost	Part Time Cost*	Full Time Cost*
Single	$975.00	$255.00	$1,113.23	$393.23	$1,188.86	$468.86
Employee & Spouse	$2,238.95	$1,518.95	$2,555.16	$1,835.16	$2,733.09	$2,013.09
Employee & Child(ren)	$1,763.62	$1,043.62	$1,994.08	$1,274.08	$2,108.25	$1,388.25
Employee & Family	$2,908.32	$2,188.32	$3,314.42	$2,594.42	$3,550.60	$2,830.60

*You can also obtain a 90 day supply of medications for two copays at CVS/Target. This only applies to CVS/Target locations. Should you go to any other network pharmacy, you will pay three copays.

This chart is a summary of select benefit options offered under KenCrest Services' medical plans. For more information, please refer to the plan documents. KenCrest Services' medical plans are written under a Pennsylvania contract, therefore, other states' mandated laws do not apply to coverage. In the event of a discrepancy between this summary and the plan documents, the plan documents will govern.

Health Savings Account (HSA)

KenCrest offers two High Deducible Health Plan (HDHP) options. When you select one of these options, you are also eligible to enroll in a Health Saving Account (HSA). You can use funds from your HSA to pay for qualified medical expenses, such as doctor's office visits, hospitalization, dental and vision. Any dollars remaining in your HSA at the end of the year will carry over to the next year. Please note that if you enroll in the HDHP 3000, you will automatically be enrolled in an HSA (administered by PayFlex). KenCrest then deposits $100 per month into your account that you can use to pay for your medical expenses. You can also choose to contribute additional funds into your HSA up to the IRS allowed annual maximum.

If you enroll in the HDHP 2000 plan, no funds are deposited by KenCrest and if you wish to contribute your own funds, you would need to open an account with PayFlex. With both plans, you can start, stop or modify your HSA contributions at any time, not only during Open Enrollment.

With a Health Savings Account:

- You own it, even if you change jobs, change health plans, or retire
- No use it or lose it rule
- Use it for qualified medical, pharmacy or other health care expenses (vision, chiropractic, etc.)
- Use it as a retirement plan for your future health care needs, similar to a 401(k) plan
- Deposits are not taxed; withdrawals for qualified medical expenses are tax-free and income from investments or interest is not taxed
- Employees age 55 and older can make an additional $1,000 "catch-up" contribution annually

In addition to reducing your taxable income, the money that you place in your HSA can also earn interest. Initially the HSA is a cash account; however once you have a balance of $2,500 in your account, you have the opportunity to move your money into mutual fund investments. Certain charges and restrictions may apply.

The annual maximum that may be deposited into a Health Savings Account in 2022 is:

- $3,650 for employee only
- $7,300 for employee with one or more dependents

For employees age 55 and older, an extra $1,000 in catch up contributions may also be made.

IMPORTANT – You may not be enrolled in any other outside health plans if participating in the Health Savings Account. This includes (but is not limited to) Medicaid, Medicare, Tricare, or a spouse's Flexible Spending Account (FSA) that covers your expenses. A HIPAA certificate indicating loss of coverage may be requested as proof.

Dental Benefits

Good dental health is important to your overall well-being. At the same time, we all need different levels of dental treatment. It is for this reason that KenCrest offers three dental plans through Aetna. These plans offer a wide range of dental benefits, from routine preventive and basic care to major services and orthodontia.

Employees working at least 20 hours per week are eligible to participate in one of KenCrest's dental programs.

Aetna DMO Plan

The low cost option is the Aetna DMO Plan. This plan offers the lowest per payroll contribution with no annual maximum benefit. Please see the schedule of benefits for more details. This DMO plan utilizes a very specific network of providers. You must elect a primary dentist and obtain all referrals from this primary dentist to obtain covered services. There is no coverage when seeking treatment from a non-participating provider.

Aetna Value PPO Plan

The Value PPO plan provides coverage of preventive and basic services but excludes major services. However, a reduced fee is charged for major and orthodontic services received in-network. Members of the plan are not required to choose a primary dental office, and they have the ability to seek treatment from an out-of-network provider.

Aetna PPO Plan

The Aetna PPO Plan has the highest per payroll contributions. Please see the schedule of benefits for more details. With this plan you do not elect a primary dentist and you have access to a much larger network of providers nation-wide than the DMO plan. Coverage is available should your dentist not participate in the Aetna network; however you may be balance billed for the visit.

Dental Benefits

	DMO	Value PPO	PPO
	In-Network Only	In & Out-of-Network	In & Out-of-Network
Annual Deductible	None	Individual: $50 / Family: $150	Individual: $50 / Family: $150
Preventive Care (Periodontics, Endodontics, Oral Surgery)	Copay varies	100%*	100%*
Basic Services	Copay varies	70%	80%
Major Services	Copay varies	Not covered	50%
Annual Maximum Benefit	Unlimited	$1,500*	$1,500*
Orthodontics Services	Copay varies (Adult & Child)	Not covered	50% to $1,500 Lifetime Max (Child Only)

Dental Monthly Contributions

	DMO	Value PPO	PPO
	In-Network Only	In & Out-of-Network	In & Out-of-Network
Employee	$16.98	$23.22	$34.93
Employee + 1	$34.65	$42.25	$73.37
Employee + 2 or more	$51.35	$70.73	$104.46

* PPO and Value PPO Plans: Obtain one Preventive Service over the next year and get an increase in your calendar year annual maximum benefit for the following plan year as follows: • PPO Dental Plan increase will be $200! • PPO Value Plan increase will be $100!

NOTE: Eligible to a maximum of 3 increases. Does not apply to the Orthodontic Benefit.

Flexible Spending Account (FSA)

KenCrest allows you to redirect a portion of your pay, through payroll deduction, into Flexible Spending Accounts (FSAs) administered by American Benefits Group. The money that goes into an FSA is deducted from your pay on a pre-tax basis (before Federal and Social Security taxes are calculated). As a result, you do not pay these taxes on money that goes into an FSA, you decrease your taxable income and potentially increase your spendable income.

With a Health Care FSA, you can begin to use all or some of the total amount elected as soon as the plan year begins. With a Dependent Care FSA, you will be reimbursed only for dependent care services that you have already funded in your account. If you submit a claim for an amount that exceeds your Dependent Care account balance, you will be reimbursed on a pay period basis until you have made enough additional contributions to cover the expenses.

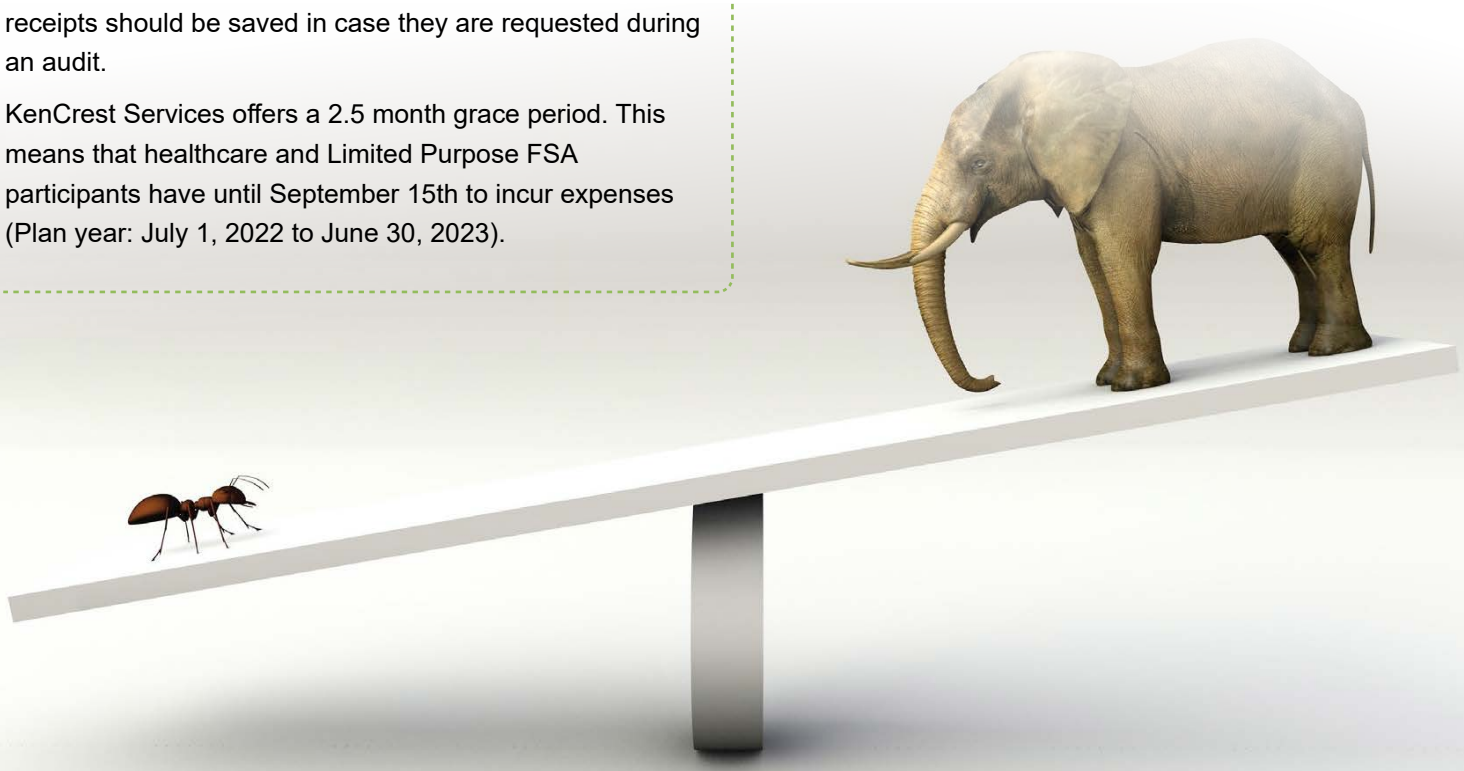
Employees working at least 20 hours per week are eligible to participate in the FSA program.

REMINDERS:

Over-the-counter medications are now eligible for reimbursement through a Health Care FSA.

Always save your receipts. You should always save your receipts for eligible health and dependent care expenses. The IRS requires American Benefits Group to validate every transaction to ensure it is health or dependent care related. You may not be required to submit a receipt, but all receipts should be saved in case they are requested during an audit.

KenCrest Services offers a 2.5 month grace period. This means that healthcare and Limited Purpose FSA participants have until September 15th to incur expenses (Plan year: July 1, 2022 to June 30, 2023).



Flexible Spending Account (FSA)

HEALTH CARE FSA

A Health Care FSA provides you with the ability to save money on a pre-tax basis for any IRS-allowed health expenses not covered by your medical benefits. These expenses include deductibles, copays and coinsurance payments, non-reimbursed medical, dental and vision expenses, qualified over-the-counter product costs, hearing care expenses (i.e. a hearing exam or a hearing aid) and orthodontia. The maximum annual amount you can contribute to a Health Care FSA is $2,850; the minimum annual contribution amount is $100. Please note that this is a reimbursement account. Services are paid for, then submitted for reimbursement.

Note: If you enroll in the HDHP with the HSA, and you wish to enroll in an FSA as well, you may enroll in the "Limited Purpose FSA." You will be able to use your "Limited Purpose FSA" for dental, vision and hearing expenses only. You may not use the FSA for medical expenses when you are enrolled in an HSA.

The amount of money you should fund into an FSA each pay period depends on your expenses. The best way to estimate your expenses for the year is by looking over the eligible expenses you incurred over the past few years. To do so, divide the total predictable expenses by the number of pay periods in the year. The resulting number represents the amount you should consider contributing each pay period to an FSA.

The maximum annual amount you can contribute to a Health Care FSA is $2,850; the minimum annual contribution amount is $100.

DEPENDENT CARE FSA

A Dependent Care FSA provides you with the ability to set aside money on a pre-tax basis for day care expenses for your eligible dependent. Generally, expenses will qualify for reimbursement if they are the result of care for:

- your children, under the age of 13, for whom you are entitled to a personal exemption on your federal income tax return; and/or
- your spouse or other dependents, including parents, who are physically or mentally incapable of self care.

Please Note: This benefit may only be used to pay for dependent care services that enable both you and your spouse to work full-time, seek employment and/or attend school. This does not include overnight camp or over-night care.

The IRS has set the maximum allowable contribution per calendar year for a Dependent Care Flexible Spending Account as follows:

- **$5,000 for a married couple filing jointly / single parent**
- **$2,500 for a married person filing separately**

Life and AD&D Benefits

Life and Disability insurance are an important part of your financial security, especially if others depend on you for support. That's why for full time benefits eligible employees KenCrest provides, at no cost to you, Basic Life and Accidental Death and Dismemberment (AD&D) and Long Term Disability (LTD) coverage through The Hartford. You also have the option of purchasing Voluntary Supplemental Life and AD&D Insurance through The Hartford and Voluntary Short Term Disability through UNUM.

BASIC LIFE AND AD&D INSURANCE

As a full-time employee you are provided with $10,000 Basic Life and AD&D Insurance. This coverage is for the employee only. Dependents are not eligible. When you reach age 70 benefits reduce by 35%; at age 75, they reduce by 50%.

	Coverage Amount	Benefit Maximum	Guarantee Issue
Basic Life and AD&D	$10,000	$10,000	N/A
Voluntary Supplemental Life			
Employee	$10,000 increments	$500,000 (not to exceed 5X your base annual earnings)	Lesser of $100,000 or 3X your base annual earnings
Spouse	$5,000 increments	$250,000 not to exceed 100% of Employee Voluntary Supplemental Life Amount	$30,000
Child(ren)	$2,000 increments	$10,000	N/A

Term Life Monthly Rates			
Age Band	**Employee per $1,000**	**Spouse Per $5,000**	**Child Per $2,000**
< 25	$0.65	$0.69	Under 25: $0.44 (includes all children)
25-29	$0.57	$0.57	
30-34	$0.70	$0.58	
35-39	$1.05	$0.74	
40-44	$1.55	$1.03	
45-49	$2.46	$1.62	
50-54	$3.83	$2.57	
55-59	$5.75	$3.97	
60-64	$7.97	$7.08	
65-69	$13.31	$12.28	
70-74	23.65	$22.27	
75-79	48.87	$42.80	

Your age band for the entire plan year is determined by your age on July 1, 2022. Please refer to the Life Insurance Handbook for details.

Life and AD&D Benefits

VOLUNTARY SUPPLEMENTAL LIFE INSURANCE

This program is available to employees working at least 20 hours per week. If you need additional protection beyond the Basic Life insurance provided to you, you may purchase Voluntary Supplemental Life Insurance for yourself and your eligible dependents. You must be enrolled in Voluntary Supplemental Life Insurance in order to purchase coverage for your eligible dependents. If you elect this coverage, you will be responsible for paying 100% of the benefit cost and will have deductions taken from your paycheck in after-tax dollars. The benefit paid is tax free. The benefit amount reduces by 35% at age 70, and by 50% at age 75. When you are first eligible, you may elect up to the GUARANTEED ISSUE AMOUNT noted below without a health questionnaire, Evidence of Insurability (EOI).

Employees with existing Voluntary Supplemental Life Insurance can increase their Voluntary Supplemental Life amount by one increment of $10,000 each year (up to the guaranteed issue amount of lesser of 3X salary or $100,000) without Evidence of Insurability (EOI). Spouses with existing Voluntary Supplemental Life Insurance can increase their Voluntary Supplemental Life Insurance amount by one increment of $5,000 each year (up to the guaranteed issue amount of $30,000) without EOI. There is no EOI required for child(ren).

If you do not elect any coverage when first eligible, all future amounts requested will require a health questionnaire (EOI) to be completed and submitted for approval.

VOLUNTARY SUPPLEMENTAL AD&D INSURANCE

Accidents are sudden and untimely, leaving family members without time to put their finances in order. In addition to helping to provide protection against financial hardships that can occur when death is the result of an accident, Accidental Death & Dismemberment (AD&D) insurance can also help during a recovery and rehabilitation period if you suffer an accidental dismemberment.

If you are enrolled in Voluntary Supplemental Life Insurance, you can also elect Voluntary Supplemental AD&D insurance for yourself and your dependents as outlined below. The elected AD&D amount must be less than or equal to the amount elected for Voluntary Supplemental Life Insurance.

- Employee: $10,000 increments up to the approved Voluntary Supplemental Life Insurance amount. Monthly Rate per $10,000 = $0.30
- Spouse: $5,000 increments up to the approved Voluntary Supplemental spouse Life Insurance amount. Monthly Rate per $5,000 = $0.15
- Child(ren): $2,000 increments up to the approved Voluntary Supplemental child(ren) Life Insurance amount. Monthly Rate per $2,000 = $0.06

If you do not elect any coverage when first eligible, all future amounts requested will require a health questionnaire (EOI) to be completed and submitted for approval.

Disability Benefits

LONG-TERM DISABILITY

KenCrest provides full time benefit eligible employees, at no cost to you, Long Term Disability (LTD) benefits. This benefit gives you valuable income protection when you are seriously ill or injured. For purposes of the LTD plan, your pay is defined as base earnings. The LTD plan pays 40% of your Base Monthly earnings up to a maximum of $3,000 per month, subject to coordination with other benefits. Benefits may begin on the 91st day of illness or injury. The benefit is offset by any Social Security income if it was initially received after you became disabled. Long Term Disability coverage is provided to full time employees only (working at least 30 hours per week). Dependents are not eligible. The Hartford administers the LTD benefits.

VOLUNTARY SHORT-TERM DISABILITY

Voluntary Short Term Disability insurance (available to employees actively working at least 20 hours per week) can provide income if you become injured or ill due to a covered disability or covered pregnancy.

The maximum amount of time you can receive benefits for a covered disability is 13 weeks. There is a 14 day waiting period before you can begin to receive your disability benefits (you may utilize your available PTO time/LTM time). Benefit amounts are available in $50 increments up to the lesser of 70% of your weekly earnings or a $750 per week benefit maximum. UNUM administers the voluntary short term disability benefits.

Short Term Disability Policy Provisions

Pre-existing Condition Limitation: A pre-existing condition is a condition for which symptoms existed within 3 months before your coverage effective date that would cause a person to seek treatment from a physician or for which a person was treated or received medical advice from a physician, or took prescribed medicine. The determination of whether your condition qualifies as a pre-existing condition will be based on the date of disability and not the date you notify the carrier. This benefit will not be paid for the disability period if it begins during the first 12 months the policy is in force.

You can elect coverage when you are first eligible without a health questionnaire. If you enroll at any other time, a health questionnaire will need to be completed and submitted for approval.

Voluntary Short-Term Disability Benefit & Costs

Step 1: Determine the Maximum Coverage Available

You may choose the benefit amount that fills your financial needs and fits your budget. The plans available to you depend on your annual salary and are listed below:

Annual Salary is at least:	May select a weekly benefit of:	Annual Salary is at least:	May select a weekly benefit of:
$7,430	$100	$33,430	$450
$11,143	$150	$37,143	$500
$14,860	$200	$40,860	$550
$18,572	$250	$44,572	$600
$22,286	$300	$48,286	$650
$26,000	$350	$52,000	$700
$29,715	$400	$55,715	$750

Step 2: Determine Your Monthly Premium Payments

Your premium payments will be made through convenient payroll deductions. The amount of your premium will depend on your age and the amount of your insurance you elected. The rates are shown below:

Monthly Pay Table $100–$400

Age Bracket	$100	$150	$200	$250	$300	$350	$400
under 40	$8.30	$12.45	$16.60	$20.75	$24.90	$29.05	$33.20
40-44	$8.60	$12.90	$17.20	$21.50	$25.80	$30.10	$34.40
45-49	$10.00	$15.00	$20.00	$25.00	$30.00	$35.00	$40.00
50-54	$11.90	$17.85	$23.80	$29.75	$35.70	$41.65	$47.60
55-59	$14.20	$21.30	$28.40	$35.50	$42.60	$49.70	$56.80
60-64	$16.70	$25.05	$33.40	$41.75	$50.10	$58.45	$66.80
65-69	$22.00	$33.00	$44.00	$55.00	$66.00	$77.00	$88.00
70+	$29.30	$43.95	$58.60	$73.25	$87.90	$102.55	$117.20

Monthly Pay Table $450–$750

Age Bracket	$450	$500	$550	$600	$650	$700	$750
under 40	$37.35	$41.50	$45.65	$49.80	$53.95	$58.10	$62.25
40-44	$38.70	$43.00	$47.30	$51.60	$55.90	$60.20	$64.50
45-49	$45.00	$50.00	$55.00	$60.00	$65.00	$70.00	$75.00
50-54	$53.55	$59.50	$65.45	$71.40	$77.35	$83.30	$89.25
55-59	$63.90	$71.00	$78.10	$85.20	$92.30	$99.40	$106.50
60-64	$75.15	$83.50	$91.85	$100.20	$108.55	$116.90	$125.25
65-69	$99.00	$110.00	$121.00	$132.00	$143.00	$154.00	$165.00
70+	$131.85	$146.50	$161.15	$175.80	$190.45	$205.10	$219.75

*This Premium Cost Chart is for illustrative purposes only; your monthly premium cost may be slightly higher or lower due to rounding.

Premium increases due to a change in age will go in effect on the group anniversary (July 1) following the date you advance to a new age bracket.

403(b) Retirement Plan

KenCrest Services realizes the importance of saving towards retirement and has established a 403(b) plan to assist you in meeting your long term financial goals. This plan allows you to save for retirement on a tax-deferred basis. In addition, KenCrest may make contributions to the plan on your behalf.

To enroll in the Retirement Plan for the first time, please contact your applicable AIG Advisor:

Barbara Bauer (All PA and DE State Staff): 267-606-5194 or Barbara.Bauer@aig.com

George Bivolarski (CT Staff): 203-919-7561 or George.Bivolarski@aig.com

Your Additional AIG Advisors:
Maria Deysher: 215-444-3872 or Maria.Deysher@aig.com

Emily Spych: 267-780-3438 or Emily.Spych@aig.com

ELIGIBILITY

All employees (regardless of number of hours worked) are eligible to contribute their own elective deferral contributions to the Plan upon hire. For eligibility criteria regarding employer match, please see Employer Contribution Section below.

EMPLOYEE CONTRIBUTIONS

Through automatic payroll deduction, you may contribute a percentage of your eligible pay to the 403(b) plan on a pre-tax basis, up to the lesser of the annual IRS benefit maximum or 100% of compensation. You may invest your contributions in a variety of investments. Participants age 50 or older may also make additional catch-up contributions, subject to IRS regulations.

Please be aware that you may stop your contributions to the 403(b) plan at any time. If you wish to change or stop your contribution amount or resume participation in the 403(b) plan, you may do so by contacting the payroll department.

EMPLOYER CONTRIBUTIONS

Once you have been employed for two years and worked at least 1,000 hours each year, you will be eligible to receive matching contributions from KenCrest. KenCrest will match the amount you contribute to the retirement plan through payroll deduction dollar-for-dollar up to 4% of your regular salary. Your percentage contribution and any matching contribution are based on your regular pay only. You may choose to contribute from your over-time earnings as well; however, contributions from these earnings are not matched by KenCrest.

Please note that once you become eligible for the KenCrest match, even if you reduce hours, the match will continue as long you continue to contribute. This also applies if you become eligible, leave employment and are re-hired.

VESTING

When you are vested, it means that you have the permanent right to the value of your account balance if you leave the company. You are always 100% vested in the value of your employee and employer contributions in the plan.

403(b) Retirement Plan

529 COLLEGE SAVINGS PLAN

A college savings plan is a plan that allows you to save money and have it invested in order to pay for future college expenses for a child or other designated beneficiary.

There is no deadline for enrolling. You can enroll at any time!

The benefits to opening a 529 College Savings Plan are as follows:

- You establish the plan. Therefore, you own and control the account and are always in control of the assets.
- You can set up as many accounts as you want. Each account must designate a different beneficiary. The original beneficiary does not have to be a relative. You can set up an account up for anyone.
- You can contribute up to $12,000 per beneficiary per year after taxes into the plan. Others can also contribute into the plan you've set up (e.g. other family members).
- The money in the account can be used by the beneficiary to attend any accredited higher education program in any state and covers the cost of tuition, room, board, books, supplies and equipment.

BlackRock is offering this plan to KenCrest employees. As a group, you will have the following advantages:

- Contributions into the plan can be payroll deducted each pay period.
- Minimum monthly contribution amount is $25.
- Choice of 20 investment options available through the plan.
- All funds in the plan are offered at Net Asset Value (NAV). This means you pay no sales charge on investments.
- Annual $25 maintenance fee usually charged by the plan is waived.
- Average management fee is 1.04%.
- You can work with your current AIG financial representative to enroll in the plan and choose the best investment vehicles for you.

For more information you can contact a AIG representative listed in the Retirement Plan section.

Additional Benefits

VOLUNTARY HOSPITAL PLAN

Employees (and any covered dependents) enrolled in this plan could receive a cash benefit that is in addition to any benefits paid under their existing health plan. This benefit applies to inpatient hospital stays only and if admitted to the hospital, each covered member receives:

- A lump sum payment of $1,000 for one hospital stay per coverage year PLUS
- $100 per day for up to 100 days of inpatient hospital stay during the coverage year

Benefits are paid directly to the employee by check. There is no paperwork to complete if the member is covered under an Aetna medical plan; the payment will be processed automatically by completing Aetna's simplified online claims process.

- Go to www.aetnavoluntaryforms.com and use the "Online claims process" link to fill out the form and submit your claim. Aetna's system matches this claim to the medical claim, retrieves the necessary medical information and the Hospital Indemnity claim is processed.

Not an Aetna Plan member?

Use the "online claims process" link as described above, fill out the form, upload your medical paperwork, and submit your claim.

Don't have internet access?

You can request a paper claim form by calling Aetna toll-free at 888-772-9682. Mail completed forms to:

Aetna Voluntary Plans
PO Box 14079
Lexington, KY 40512-4079

This benefit can be used whether you have an HMO or POS plan (remember, KenCrest pays for the inpatient hospital copay for these plans so this would provide extra funds) or can be used with the High Deductible Health Plan to help offset the deductible. Enrollees can use the cash benefit to pay non-health related costs as well – it is up to you! There is a pre-existing condition exclusion and some services are not covered (such as cosmetic surgery) so please see the plan booklet for more details.

Hospital Plan Rates

	Monthly Rates
Employee	$20.54
Employee + Spouse	$43.24
Employee + Child(ren)	$41.16
Employee + Family	$63.84

Additional Benefits

CRITICAL ILLNESS INSURANCE (Administered by Unum)

Employees currently enrolled are Grandfathered into the current plan design. All new enrollees as of 7/1/2022 are enrolled in the new benefit plan design described here.

What is Critical Illness

Critical Illness Insurance* can help provide financial protection, by offering a lump sum benefit upon first diagnosis of a covered critical illness.

Family Coverage Options

With the purchase of a new employee policy, spouse and dependent children coverage is available for an additional cost. Employee coverage is available in the benefit amount of $10,000, $20,000, or $30,000. Spouse coverage is available in the benefit amount of $5,000, $10,000, or $15,000. Child coverage is available in the benefit amount of 25% of employee coverage amount.

New Enrollees as of 7/1/2022 are automatically enrolled in the new plan including children automatically included at 25% of employee benefit amount.

Health Screening Benefit Rider

Employees may purchase an optional health screening rider for an additional cost. This rider pays up to $50 per calendar year per insured if you receive a covered health screening test. Examples of health screenings are colonoscopy, mammogram, Pap smear, and PSA (blood test for prostate cancer).

Base Covered Critical Illnesses	Percent of Benefit Amount
Heart attack	100%
Stroke	100%
Major organ transplant	100%
Permanent paralysis	100%
End stage renal failure	100%
Coronary Artery Bypass Surgery	25%

New Enrollees as of 7/1/2022 are enrolled in a new plan including these Base Covered Critical Illnesses	
Blindness	100%
Benign brain tumor	100%
Occupational HIV	100%
Coma	100%

Enhanced Covered Critical Illnesses	Percent of Benefit Amount
Cancer	100%
Carcinoma in situ	25%

Both the Base Plan and the Enhanced Plan allow you to choose a benefit amount from $5,000 to $50,000 in $1,000 increments. Individual rates are made available during your Annual Open Enrollment Session.

Limitations

The benefit amounts for employee and spouse reduce by 50% on the first policy anniversary after the insured's 70th birthday, or five years after the policy date, whichever is later. Premiums for the policy will not be reduced. Benefits will not be paid for a pre-existing condition within the first 12 months the policy is in force. A pre-existing condition is a sickness or physical condition for which within 12 months before the coverage effective date symptoms existed that would cause a person to seek treatment or; the insured was treated, received medical advice from a physician, or had taken medicine.

Note: Starting from the 2022 Open Enrollment period and for any new hires, enrollment in Whole Life and Critical Illness only must be done on the enrollvb platform, not Dayforce. Use this custom enrollment link: http://www.enrollvb.com/kencrest.

Additional Benefits

INTEREST-SENSITIVE WHOLE LIFE INSURANCE (Administered by Unum)

Employees currently enrolled are Grandfathered into the current plan design. All new enrollees as of 7/1/2022 are enrolled in the new benefit plan design described here.

Supplemental Whole Life Insurance* is an optional life insurance benefit offered to all benefit eligible employees as a long term financial resource to protect their families. UNUM's interest-sensitive whole life insurance is designed to provide death benefits to your beneficiaries if you pass away, but it also can build cash value that you can utilize while you are still alive. At an affordable premium, you can have the added financial protection you and your family may need during times of uncertainty.

- The policy's accumulated cash value may also be used to buy a smaller, "paid up" policy on which no further premiums are due.
- No physical exams are required.
- Available for employees ages 18-75 who are actively at work.
- Family coverage options available for spouse and children.
- An Advance Benefit Option Rider is included on all employee and spouse policies with a face amount of $6,000 or greater.
- A Long Term Care Base Rider is available on employee and spouse policies. The benefit pays 6% monthly benefit for either facility or assisted living.
- A Restoration Benefits Rider is available on employee and spouse policies. The benefit restores 100% of the policies face amount, death benefit and cash value. The death benefit is $25,000.
- Individually owned coverage which means you can take your policy with you if you retire or leave the company.

Plan Rates

Individual rates are made available during your Annual Open Enrollment Period.

Note: Starting from the 2022 Open Enrollment period and for any new hires, enrollment in Whole Life and Critical Illness only must be done on the enrollvb platform, not Dayforce. Use this custom enrollment link: http://www.enrollvb.com/kencrest.

Additional Benefits

EMPLOYEE ASSISTANCE PROGRAM

Some days it can be difficult to manage the competing priorities of our lives, and keep it all running smoothly. The Employee Assistance Program (EAP), administered by Carebridge provides confidential and professional assistance round-the-clock to help you balance the demands of work, life and personal issues. Carebridge also provides access to a video and educational webinar library covering various topics.

KenCrest provides the EAP and Life Management Resources at no cost to all employees. This benefit includes up to six face-to-face counseling sessions with a professional behavioral health clinician. Also, get extra support and unlimited consultations for handling life's demands by calling for advice or a referral to a service in your community on topics such as:

- Legal Assistance – speak with a Carebridge designated attorney for a 30-minute consultation and a 25% discount off the attorney's fees for additional services.
- Child Care – a professional child care counselor will assist you in finding affordable and convenient resources for your child care needs.
- Parenting – Carebridge Specialists provide parenting guidance and resources to support parents and other caretakers in nurturing each child's growth and development.
- College Planning – Carebridge professional College Planning counselors will work with you on issues such as the correct high school program to achieve college admission, test preparation, selecting the right college, writing admission essays and more.
- Healthy Lifestyle – Carebridge Wellness Resource Specialists can refer employees/family members to nutritionists, gyms, chiropractors, personal trainers, Weight Watchers meetings and other support groups.
- Money Management – Carebridge Financial Specialists are available by telephonic consultation to assist with exploring your financial aspirations, identifying information and resources, aligning your lifestyle to your budget and establishing healthy financial habits and behaviors.
- Eldercare – Sorting through the many elder programs, services and entitlements can be complicated and confusing; your Carebridge eldercare counselor will be there to consult with you as many times as needed to work through your questions.
- Identity Theft – included under the 30-minute legal consultation or if any employee simply wants to know steps they should take, Money Management can also assist.
- Pet Care – from grooming to boarding to veterinary services, find what you need to care for your pet.

Free & Confidential
All EAP counseling and assistance is free and confidential.

Don't miss out on your chance to participate!
Visit the CareBridge website www.myliferesource.com to sign up.

Questions?
Call 800-437-0911or email clientservice@carebridge.com

Additional Benefits

ROD HIBBARD MEMORIAL FUND

The Rod Hibbard Memorial Fund is administered by KenCrest staff to provide financial support to agency employees who have experienced a financial need due to a medical, personal or disaster situation. It is funded primarily through staff contributions. You can help support this benefit by contributing to the program through payroll deduction. To donate, simply complete an authorization form (found on the Employee section of the KenCrest website). Your gift of any amount per pay can make a difference in the life of a fellow staff member.

To request financial support, please obtain an application, which is located on the Employee section of the KenCrest website. Requests are reviewed by a panel of KenCrest employees. Decisions are made as soon as possible after receipt of an application, typically within 72 hours.

All KenCrest employees who have been employed for at least one year and are in good standing can apply. Contributing to the fund is not a requirement to apply.

Additional Benefits

TUITION ASSISTANCE PROGRAM

KenCrest wants to help you achieve your educational goals. If you are enrolled in a college degree program (associate degree, bachelor's degree, master's degree, etc.) that relates to what you do at KenCrest, you could be eligible for tuition assistance money. Full-time employees who have passed their three month probationary period are eligible to apply. If approved, KenCrest will reimburse part of your tuition for one class per semester, for a maximum of four semesters per year. Please refer to the program guidelines for information regarding the current reimbursement amount.

In order to receive the tuition assistance money you must apply within the published deadlines, receive a grade of "C" or better in the class, and submit documentation of payment of tuition.

Please ask Human Resources for a copy of the application and program guidelines.

Important Legal Notices

ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with KenCrest Services 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:

- 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.
- Kencresthas determined that the prescription drug coverage offered through the company-sponsored medical plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a 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 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-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 Kencrest coverage will not be affected. You can keep your KenCrest group health plan and prescription coverage even if you elect Medicare Part D; the plan will coordinate with Part D coverage. If you are an active associate and you decide to join a Medicare drug plan and you drop your current KenCrest medical and Rx coverage, be aware that you and your dependents will be able to get this coverage back, provided you are still eligible to participate in the KenCrest Medical Plan.

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 KenCrest 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 19 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.

Important Legal Notices

For more information about this notice or your current prescription drug coverage contact Human Resources.

Contact the Human Resources Manager (whose information is provided below) for further information. NOTE: You'll receive 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 KenCrest Services changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage:

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

For more information about Medicare prescription drug coverage:

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

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

REMEMBER:

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

Date:	July 1, 2022
Name of Entity/Sender:	KenCrest Service
Contact:	Kim Smith, Senior Benefits Coordinator
Address:	960A Harvest Drive, Suite 100, Blue Bell, PA 19422
Phone Number:	(610)-825-9360, Ext. 1032

Important Legal Notices

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 January 31, 2022. Contact your State for more information on eligibility –

Important Legal Notices

ALABAMA—Medicaid myalhipp.com 1-855-692-5447

ALASKA—Medicaid
The AK Health Insurance Premium Payment Program myakhipp.com
1-866-251-4861 Customer Service@MyAKHIPP.com
Medicaid Eligibility: dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS—Medicaid
myarhipp.com 1-855-MyARHIPP (855-692-7447)

COLORADO—Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA—Medicaid flmedicaidtplrecovery.com/hipp 877-357-3268

GEORGIA—Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

INDIANA—Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479

All other Medicaid
Website: http://www.indianamedicaid.com Phone 1-800-403-0864

IOWA—Medicaid http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563

KANSAS—Medicaid www.kdheks.gov/hcf 1-785-296-3512

KENTUCKY—Medicaid chfs.ky.gov/dms/default.htm 1-800-635-2570

LOUISIANA—Medicaid
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE—Medicaid
www.maine.gov/dhhs/ofi/public-assistance/index.html
1-800-442-6003 TTY: Maine relay 711

MASSACHUSETTS—Medicaid and CHIP
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA—Medicaid
https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI—Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA—Medicaid
dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
1-800-694-3084

NEBRASKA—Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633 Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA—Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE—Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY—Medicaid and CHIP
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK—Medicaid
www.nyhealth.gov/health_care/medicaid 800-541-2831

NORTH CAROLINA—Medicaid www.ncdhhs.gov/dma
919-855-4100

NORTH DAKOTA—Medicaid
www.nd.gov/dhs/services/medicalserv/medicaid
1-844-854-4825

OKLAHOMA—Medicaid and CHIP
www.insureoklahoma.org 1-888-365-3742

OREGON—Medicaid
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA—Medicaid
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND—Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA—Medicaid www.scdhhs.gov 1-888-549-0820

SOUTH DAKOTA—Medicaid dss.sd.gov 1-888-828-0059

TEXAS—Medicaid gethipptexas.com 1-800-440-0493

UTAH—Medicaid and CHIP
Medicaid: health.utah.gov/medicaid
CHIP: health.utah.gov/chip 1-877-543-7669

VERMONT—Medicaid www.greenmountaincare.org 1-800-250-8427

VIRGINIA—Medicaid and CHIP
Medicaid: www.coverva.org/programs_premium_assistance.cfm
1-800-432-5924
CHIP: www.coverva.org/programs_premium_assistance.cfm 855-242-8282

WASHINGTON—Medicaid
www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
1-800-562-3022 ext. 15473

WEST VIRGINIA—Medicaid
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN—Medicaid and CHIP
www.dhs.wisconsin.gov/publications/p1/p10095.pdf 800-362-3002

WYOMING—Medicaid wyequalitycare.acs-inc.com 1-307-777-7531

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
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.

Important Legal Notices

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Part A: General Information

The Patient Protection and Affordable Care Act of 2010, commonly known as the health care reform law, focuses on expanding access to affordable medical insurance and health care to all American citizens. Citizens are now able to access medical insurance through a public Health Insurance Marketplace, and federal subsidies may be available to help pay for Marketplace coverage. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer. For more information, visit www.HealthCare.gov.

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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

Important Legal Notices

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

Information About Health Coverage Offered by KenCrest Services

If you decide to complete an application for coverage in the Marketplace, you will be asked to provide the following information. This information is numbered to correspond with the Marketplace application:

Employer Name: KenCrest Services

Employer Identification Number (EIN): 23-1439925

Employer Address: 960A Harvest Drive, Suite 100, Blue Bell PA 19422

Employer Telephone Number: 610-825-9360

Contact for Employee Health Coverage: Kim Smith, Human Resources

Email Address of Contact: ksmith@kencrest.org

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

As your employer, we offer a health plan to some employees. Eligible employees are Employees who meet the service requirements for their program and work a minimum of 20 hours per week. Full-Time employees working a minimum of 30 hours per week will receive the employer contribution towards health insurance. Part-time employees working a minimum of 20 hours per week may purchase health insurance at full cost.

With respect to dependents:

With respect to dependents, we do offer coverage. Eligible dependents are spouses, children to the end of the month of their 26th birthday and children who are incapable of self-sustaining employment by reason of mental or physical handicap, if covered as a dependent prior to age 26, children for whom the employee must provide health insurance by a qualified medical child support order (QM CSO).

This coverage meets the minimum value standard, and the cost of this coverage is intended to be affordable** to most of our employees based on employee wages. The law currently defines our plan as affordable as long as 9.61% of your household taxable income (referred to as MAGI by the government) is more than the lowest employee only payroll contribution.

Here is what the government tells us about how to determine your household taxable income:

When you fill out the Marketplace application, a number called “modified adjusted gross income” (MAGI) will be used. Modified adjusted gross income is generally your household’s adjusted gross income plus any tax-exempt Social Security, interest, and foreign income you have. It’s used to determine your eligibility for lower costs on Marketplace coverage, and for Medicaid and the Children’s Health Insurance Program (CHIP). (Your adjusted gross income is your income minus your tax deductions.)

You don’t have to figure out this income yourself. The math will be done for you when you apply through the Marketplace or your state agency

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

Please note that if you decide to shop for coverage in the Marketplace, www.HealthCare.gov will guide you through the process.

Important Legal Notices

Genetic Information Non-Discrimination Act

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual. GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record, and may be disclosed to third parties only in very limited circumstances.

Newborn's 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 issuer for prescribing a length of stay not in excess of 48 (or 96) hours.

Qualified Medical Child Support Order

A QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Michelle's Law

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage. The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued until:

- One year from the start of the medically necessary leave of absence, or
- The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

Women's Health And Cancer Rights Act (Janet's Law)

The Women's Health and Cancer Rights Act requires that all medical plans cover breast reconstruction following a mastectomy. Under this law, if an individual who has had a mastectomy elects to have breast reconstruction, the medical plan must provide the following coverage as determined in consultation with the attending physician and the patient:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications at all stages of the mastectomy, including lymphedemas

Benefits received for the above coverage will be subject to any deductibles and coinsurance amounts required under the medical plan for similar services. The Act prohibits any group health plan from:

- Denying a participant or a beneficiary eligibility to enroll or renew coverage under the plan in order to avoid the requirements of the Act;
- Penalizing, reducing, or limiting reimbursement to the attending provider (e.g. physician, clinic or hospital) to induce the provider to provide care inconsistent with the Act; and providing monetary or other incentives to an attending provider to induce the provider to provide care inconsistent with the Act.

Contact Information

Benfit	Carrier	Website/Email	Phone
Medical	Aetna	www.aetna.com	800-962-6842
Prescription Drugs	Aetna	www.aetna.com	888-792-3862
Specialty Pharmacy	Aetna	www.aetna.com	866-782-ASRX (2779)
Vision	Aetna	www.aetna.com	888-982-3862
Dental	Aetna	www.aetna.com	877-238-6200
Hospital Plan	Aetna	www.aetna.com	888-772-9682
PayFlex	Aetna	www.aetna.com	844-PayFlex (729-3539)
Teladoc	Aetna	www.teladoc.com/aetna or teladoc.com/mobile	855-TELADOC (835-2362)
Health Care Flexible Spending Accounts	American Benefits Group	www.myflexresource.com claims@amben.com	800-499-3539
Dependent Care Flexible Spending Accounts	American Benefits Group	www.myflexresource.com claims@amben.com	800-499-3539
Basic Life and AD&D Insurance	The Hartford	www.thehartford.com	888-563-1124
Supplemental Life/AD&D Insurance	The Hartford	www.thehartford.com	888-563-1124
Long Term Disability Insurance (LTD)	The Hartford	www.thehartford.com	888-301-5615
Critical Illness Insurance	Unum	www.unum.com	800-635-5597
Whole Life Insurance	Unum	www.unum.com	800-635-5597
Short Term Disability Insurance (STD)	Unum	www.unum.com	800-421-0344
403(b) Retirement Plan	AIG	www.aig.com	800-448-2542
529 College Savings Plan	The Blackrock 529	www.blackrock/collegeadvantage.com	866-529-8582
Employee Assistance Program (EAP)	Carebridge	www.myliferesource.com Access code: 3AC8A clientservice@carebridge.com	800-437-0911

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2022 BENEFITS GUIDE