KIER CONSTRUCTION CORPORATION

Welfare Benefit Plan

Plan Document

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Summary Plan Description

Amended and Restated
January 1, 2017

Introduction

Kier Construction Corporation (the "Employer") maintains the **Kier Construction Corporation Welfare Benefit Plan** ("the Plan") for the exclusive benefit of its eligible employees and their eligible dependents. Benefits under the Plan are currently provided under a group insurance contract entered into between the Employer and various Insurance carriers and Third Party Administrators.

Plan benefits, including information about eligibility, are summarized in the Certificate of Coverage, Member Payment Summary, and Provider & Facility Directory issued by the selected insurance carriers, copies of which are available from your Human Resources Department, free of charge. These documents together with this document constitute the Summary Plan Description required by the federal law known as the Employee Retirement Income and Security Act ("ERISA"). Capitalized terms not otherwise defined in this document are defined in the Certificate of Coverage.

Specific Plan Information

Plan Name:	**Kier Construction Corporation Welfare Benefit Plan**
Type of Plan:	**A group Health, Dental, Vision, Health Reimbursement Arrangement, Disability and Life Insurance program. The plan also provides Individual selected Accident, Cancer, Hospital, and Dental Insurance.**
Plan Year:	**January 1 to December 31**
Plan Number:	**502**
Employer / Plan Sponsor:	**Kier Construction Corporation** **3710 Quincy Avenue** **Ogden, Utah 84403**
Plan Funding and Type of Administration:	The Plan is both self-funded and fully insured. Benefits are provided under the Group Insurance Contracts between the Employer and **Tall Tree Administrators, Sun Life Assurance Company of Canada, Standard Insurance Company, Colonial Life Insurance Company, American Family Life Assurance Company and Wasatch Employee Benefit Services.** Claims for benefits are sent to the respective insurance companies which are responsible for paying claims. Both the insurance carriers and the Employer share responsibility for administering the Plan. Insurance premiums for employees and their eligible dependents are paid in part by the Plan Sponsor out of its general assets, and in part by employees' payroll deductions.
Plan Sponsor's Employer Identification Number:	**87-0435003**
Plan Administrator:	**Kier Construction Corporation** **3710 Quincy Avenue** **Ogden, Utah 84403** **801-627-1414**

Named Fiduciary:	**Kier Construction Corporation** **3710 Quincy Avenue** **Ogden, Utah 84403** **801-627-1414**
Agent for Service of Legal Process:	**Kier Construction Corporation** **3710 Quincy Avenue** **Ogden, Utah 84403** **801-627-1414**
Important Disclaimer:	Plan benefits are provided under self-funded and fully insured contracts between the Employer and **Tall Tree Administrators, Sun Life Assurance Company of Canada, Standard Insurance Company, Colonial Life Insurance Company, American Family Life Assurance Company and Wasatch Employee Benefit Services.** If the terms of this summary document conflict with the terms of the Group Insurance Contract, the terms of the Group Insurance Contract will control, unless superseded by applicable law.

ID Cards

You will be issued an ID Card after you enroll with the carrier. Please carry your ID Card with you and present it each time you receive care.

If you lose your ID Card, you can request a new one by calling **Tall Tree Administrators, Sun Life Assurance Company of Canada, Standard Insurance Company, Colonial Life Insurance Company, American Family Life Assurance Company and Wasatch Employee Benefit Services** member services or contacting your Human Resources Department.

Eligibility

In order to be Eligible for Benefits you must be scheduled to work 30 or more hours per week, and have (60) days of continuous employment. During the Employer Waiting Period, you must work the specified minimum required hours except for paid time off and hours you do not work due to a medical condition, the receipt of healthcare, your health status or disability. **Tall Tree Administrators, Sun Life Assurance Company of Canada, Standard Insurance Company, Colonial Life Insurance Company, American Family Life Assurance Company and Wasatch Employee Benefit Services** may require payroll reports from your employer to verify the number of hours you have worked as well as documentation from you to verify hours that you did not work due to paid time off, a medical condition, the receipt of healthcare, your health status or disability.

To determine whether your spouse and dependent children are eligible to participate in the Plan, please read the eligibility information contained in the Certificate of Coverage issued by **Tall Tree Administrators, Sun Life Assurance Company of Canada, Standard Insurance Company, Colonial Life Insurance Company, American Family Life Assurance Company and Wasatch Employee Benefit Services.**

The Plan will extend benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are your natural children. Also eligible is any child covered under a Qualified Medical Child Support Order (QMCSO) as defined by applicable law and

determined by your Employer under its QMCSO procedures, a copy of which is available from your Human Resources Department, free of charge.

If eligible, you must complete an application form to enroll in the Plan and **Tall Tree Administrators, Sun Life Assurance Company of Canada, Standard Insurance Company, Colonial Life Insurance Company, American Family Life Assurance Company and Wasatch Employee Benefit Services** (available from your Human Resources Department) or otherwise comply with your Employer's enrollment procedures.

Coverage will terminate if you no longer meet the eligibility requirements. Coverage may also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, if you submit false claims, etc. (See the Certificate of Coverage for more information.) Coverage for your spouse and dependents stops when your coverage stops. Their coverage will also stop for other reasons specified in the Certificate of Coverage.

Special Situations, Extension of Coverage

Family and Medical Leave Act (FMLA)

If the Family Medical Leave Act (FLMA) applies to your Employer and you qualify for an approved family or medical leave of absence (as defined in the FMLA), eligibility may continue for the duration of the leave if required contributions are paid toward the cost of the coverage. Your Employer has the responsibility to provide you with prior written notice of the terms and conditions under which payment must be made. Failure to make payment within 30 days of the due date established by your Employer will result in the termination of coverage. Subject to certain exceptions, if you fail to return to work after the leave of absence, your Employer has the right to recover from you any contributions toward the cost of coverage made on your behalf during the leave, as outlined in the FMLA.

If coverage is terminated for failure to make payments while you are on an approved family or medical leave of absence, coverage for you and your eligible dependents will be automatically reinstated on the date you return to employment if you and your dependents are otherwise eligible under the plan. Any waiting period for pre-existing conditions or other waiting periods will not apply. However, all accumulated annual and lifetime maximums will apply.

If you do not return to work at the end of an FMLA leave, you may be entitled to elect COBRA Continuation Coverage, even if you were not covered under the Plan during the leave. Coverage continued under this provision is in addition to coverage described below under the section entitled "Continuation Coverage (COBRA)."

The Plan intends to comply with all existing FMLA regulations. If for some reason the information presented differs from actual FMLA regulations, the Plan reserves the right to administer the FMLA in accordance with such actual regulations.

Military Leave Coverage

The Uniformed Services Employment and Reemployment Rights Act (USERRA) establishes requirements that employers must meet for certain employees who are involved in the uniformed services

As used in this provision, "Uniformed Services" means:

- The Armed Forces;
- The Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (pursuant to orders issued under federal law);

- The commissioned corps of the Public Health Service; and
- Any other category of persons designated by the President in time of war or national emergency.

As used in this provision, "Service in the Uniformed Services" or "Service" means the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes:

- Active duty;
- Active duty for training;
- Initial active duty training;
- Inactive duty training;
- Full-time National Guard duty,
- A period for which you are absent from your job for purpose of an examination to determine your fitness to perform any such duties;
- A period for which you are absent from your job for the purpose of performing certain funereal honors duty; and
- Certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

If you were covered under this Plan immediately prior to taking a leave for Service in the Uniformed Services, you may elect to continue your coverage under USERRA for up to 24 months from the date your leave for uniformed service began, if you pay any required contributions toward the cost of the coverage during the leave. This USERRA continuation coverage will end earlier if one of the following events takes place:

1) You fail to make a premium payment within the required time;
2) You fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service; or
3) You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or less, your contribution amount will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage described below under the section entitled "COBRA Continuation Coverage."

If your coverage under the Plan terminated because of your Service in the Uniformed Services, your coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period(s) required by USERRA.

When coverage under this Plan is reinstated, all of the Plan's provisions and limitations will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by your military service, as determined by the VA. (For complete information regarding your rights under USERRA, contact your Employer.)

The Plan intends to comply with all existing regulations of USERRA. If for some reason the information presented in the Plan differs from the actual regulations of USERRA, the Plan reserves the right to administer the plan in accordance with such actual regulations.

COBRA Continuation Coverage

COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." The following are qualifying events:

- Termination of your employment for any reason except gross misconduct. Coverage may continue for you and/or your eligible dependents;

- A reduction in your hours. Coverage may continue for you and/or your eligible dependents;
- Your death. Coverage may continue for your eligible dependents;
- Your divorce or legal separation. Coverage may continue for your eligible dependents;
- Your becoming entitled to Medicare. Coverage may continue for your eligible dependents; and
- Your covered dependent child's ceasing to be a dependent child under the Plan. Coverage may continue for that dependent.

Note: To choose this continuation coverage, an individual must be covered under the Plan on the day before the qualifying event. In addition, your newborn child or child placed for adoption with you during a period of continuation coverage will remain eligible for continuation coverage for the remaining period of coverage even if you and/or your spouse terminate continuation coverage following the child's birth or placement for adoption.

Notification Requirements

Under the law, you or the applicable dependent has the responsibility to inform the Plan Administrator, in writing, within 60 days of a divorce or legal separation or of a child losing dependent status under the Plan. Failure to provide this written notification within 60 days will result in the loss of continuation coverage rights.

Your Employer has the responsibility to notify the Plan Administrator of your death, termination of employment, reduction in hours, or entitlement to Medicare within 30 days of the qualifying event.

Subject to the Plan Administrator being informed in a timely manner of the qualifying events described in the above paragraphs, the Plan will promptly notify you and other qualifying individual(s) of their continuation coverage rights. You and any applicable dependents must elect continuation coverage within 60 days after Plan coverage would otherwise end, or, if later, within 60 days of the notice of continuation coverage rights. Failure to elect continuation coverage within this 60-day period will result in loss of continuation coverage rights.

Trade Act of 2002

If you qualify for Trade Adjustment Assistance (TAA) as defined by the Trade Act of 2002, they you will be provided with an additional 60 day enrollment period, with continuation coverage beginning on the date of such TAA approval.

Notice of Unavailability of Continuation Coverage

If the Plan Administrator receives a notice of a qualifying event from you or your dependent and determines that the individual (you or your dependent) is not entitled to continuation coverage, the Plan Administrator will provide to the individual an explanation as to why the individual is not entitled to continuation coverage. This notice will be provided within the same time frame that the Plan Administrator would have provided the notice of right to elect continuation coverage.

Maximum Period of Continuation Coverage

The maximum period of continuation coverage is 36 months from the date of the qualifying event, unless the qualifying event is your termination of employment or reduction in hours. In that case, the maximum period of continuation coverage is generally 18 months from the date of the qualifying event.

However, if a qualifying individual is disabled (as determined under the Social Security Act) at the time of your termination or reduction in hours or becomes disabled at any time during the first 60 days of continuation coverage, continuation coverage for the qualifying individual and any non-disabled eligible dependents who are also entitled to continuation coverage may be extended to 29 months provided the qualifying individual or dependent, if applicable, notifies the Plan Administrator in writing within the 18-month continuation coverage period and within 60 days after receiving notification of determination of disability.

If a second qualifying event occurs (for example, your death or divorce) during the 18- or 29-month coverage period resulting from your termination of employment or reduction in hours, the maximum period of coverage will be computed from the date of the first qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event.

A special rule applies if the qualifying individual is your spouse or dependent child whose qualifying event was the termination or reduction in hours of your employment and you became entitled to Medicare within 18 months before such qualifying event. In that case, the qualifying individual's maximum period of continuation coverage is the longer of 36 months from the date of your Medicare entitlement or their otherwise applicable maximum period of coverage.

Cost of Continuation Coverage

The cost of continuation coverage is determined by the Employer and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable premium cannot exceed 102 percent of the Plan's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150 percent of the Plan's cost of coverage.

Premium payments for continuation coverage for you or your eligible dependent's "initial premium month(s)" are due by the 45th day after electing continuation coverage. The "initial premium month(s)" are any month that ends on or before the 45th day after you or the qualifying individual elects continuation coverage. All other premiums are due on the first of the month for which coverage is sought, subject to a 30-day grace period. Premium rates are established by your Employer and may change when necessary due to Plan modifications. The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

When Continuation Coverage Ends

Continuation of coverage ends on the earliest of:

1. The date the maximum continuation coverage period expires;
2. The date your Employer no longer offers a group health plan to any of its employees;
3. The first day for which timely payment is not made to the Plan;
4. The date the qualifying individual becomes covered by another group health plan. However, if the new plan contains an exclusion or limitation for a pre-existing condition of the qualifying individual, continuation coverage will end as of the date the exclusion or limitation no longer applies;

5. The date the qualifying individual becomes entitled to coverage under Medicare; and
6. The first day of the month that begins more than 30 days after the qualifying individual who was entitled to a 29-month maximum continuation period is subject to a final determination under the Social Security Act that he or she is no longer disabled.

Note: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all health insurance carriers that offer coverage in the individual market accept any eligible individuals who apply for coverage without imposing a pre-existing condition exclusion. In order to be eligible to apply for such coverage from a carrier after ceasing participation in the Plan, you or your eligible dependents must elect continuation coverage under the Plan, continue through the maximum continuation coverage period (18, 29, or 36 months, as applicable), and then apply for coverage with the individual insurance carrier before a 63 day lapse in coverage. For more information about your right to such individual insurance coverage, contact an independent insurance agent or your state insurance commissioner.

Notice of Termination Before Maximum Period of COBRA Coverage Expires

If continuation coverage for a qualifying individual terminates before the expiration of the maximum period of continuation coverage, the Plan Administrator will provide notice to the individual of the reason that the continuation coverage terminated, and the date of termination. The notice will be provided as soon as practicable following the Plan Administrator's determination regarding termination of the continuation coverage.

The Plan intends to comply with all applicable law regarding continuation (COBRA) coverage. If for some reason the information presented in this Plan differs from actual COBRA requirements, the Plan reserves the right to administer COBRA in accordance with such actual COBRA requirements.

Federal Notices

Qualified Medical Child Support Orders

The Plan Administrator will adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations settlement agreement) which

(1) Relates to the provision of child support related to health benefits for a child of a Participant of a group health plan;
(2) Is made pursuant to a state domestic relations law; and,
(3) Which creates or recognizes the right of an alternate recipient to, or assigns to an alternate recipient the right to receive benefits under the group health plan under which a Participant or other beneficiary is entitled to receive benefits.

The Plan Administrator will promptly notify the participant and each alternate recipient named in the medical child support order of the Plan's procedures for determining the qualified status of the medical child support orders. Within 30 days of receipt of a medical child support order, the Plan Administrator will determine whether such order is a qualified medical child support order and will notify the participant and each alternate recipient of that determination. If the Participant or any affected alternate payee objects to the determinations of the Plan Administrator, the disagreeing party will be treated as a claimant and the claims procedure of the Benefit Plan will be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

A Qualified Medical Child Support Order (QMCSO) must clearly specify the name and last known mailing address of the Participant, name and address of each alternate recipient covered by the order, a description of the coverage to be provided by the group health plan or the manner in which such coverage is to be determined, the period of coverage that must be provided, and each plan to which such order applies.

A QMCSO will not require the Plan to provide any type or form of benefit, or any option, that it is not already offering except as necessary to meet the requirements of a state medical child support law described in Section 1908 of the Social Security Act as added by Section 13822 of the Omnibus Reconciliation Act of 1993 (OBRA '93). Upon determination of a Qualified Medical Child Support Order, the Plan must recognize the QMCSO by providing benefits for the Participant's child in accordance with such order and must permit the parent to enroll under the family coverage any such child who is otherwise eligible for coverage without regard to any enrollment season restrictions.

The Federal Privacy Rule

Plan Sponsors who receive Protected Health Information are subject to the federal privacy rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as described below.

Protected Health Information ("PHI") means: information that is created or received by the Plan Sponsor and relates to the past, present, or future physical or mental health or condition of any participant; or, the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant. The test is whether there is a reasonable basis to believe the information can be used to identify the participant. PHI includes information of persons living or deceased. PHI as used in this document includes data that is transmitted or stored electronically.

Access To PHI: The Plan Sponsor's access to PHI is restricted to the minimum information necessary to administer the Benefit Plan. This includes obtaining Participant elections and enrollment for payroll and Benefit Plan administration. The Plan Sponsor may have access to PHI that was submitted for claims reimbursement when that claim is on an appeal from an adverse decision. Only the Benefits Coordinator and employees trained in the federal privacy rule will have access to the PHI.

Permitted And Required Uses And Disclosures Of PHI By The Plan Sponsor: The Plan Sponsor can only use and disclose PHI for plan administration functions as permitted and required by this Plan Document, or as required by law. The Plan Sponsor will not use or disclose PHI for employment-related actions or in connection with any other employee benefit plan. When necessary, the Benefits Coordinator will disclose the PHI to consultants and experts as required by the Department Of Labor for a full and fair review or to perform plan non-discrimination testing as required by law. All other disclosures of PHI will only be made pursuant to a valid authorization from the Participant that meets the requirements of 45 CFR §164.508.

The Plan Sponsor, on behalf of the Plan, may disclose Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance or modifying, amending or terminating the Plan. Summary Health Information means information that summarizes claims history and expenses which meets the federal requirements that remove all data fields that can be used to identify an individual participant.

Complaints: If a Participant has any complaints regarding the way that the Plan Sponsor has handled PHI they can complain to the Benefits Coordinator. No response from the Benefits Coordinator is required. A copy of this complaint procedure shall be provided to the Participant upon request. The Benefits Coordinator will keep a copy of the complaint, applicable documentation, and disposition if any, for a period of 6 years from the end of the plan year in which the act occurred.

No Retaliation: No Employer will intimidate, threaten, coerce, discriminate against, or take other retaliatory action against Participants for exercising their rights, filing a complaint, participating in an investigation, or opposing any improper practice under the federal Privacy Rule.

Firewall: The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the protected health information that it creates, receives, maintains, or transmits on behalf of the group health plan; and ensure

that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information.

Plan Sponsor will: 1) Ensure that any subcontractors or agents to whom the Plan Sponsor provides PHI agree to the same restrictions described above, 2) report to the health plan any use or disclosure that is inconsistent with this Plan Document or the federal Privacy Rule, 3) make the PHI information accessible to the Participants, 4) allow Participants to amend their PHI, 5) provide an accounting of its disclosures of PHI as required by the Privacy Rule, 6) make its practices available to the Secretary for determining compliance, and, 7) return and destroy all PHI when no longer needed, if feasible.

The Federal Security Rule

This Term is intended to bring the Plan into compliance with the "HIPAA Security Rule" as published on February20, 2003 by the United States Department of Health and Human Services (HHS), and amended, including the final Security Standards under the Health Insurance Portability and Accountability Act of 1996 and the HITECH Act (Health Information Technology for Economic and Clinical Health Act) of 2009.

The Electronic Media contemplated by the HIPAA Security Rule includes:

(1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

(2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a Business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic Form before the transmission.

In order to send and receive Protected Health Information ("PHI" as defined in the Plan Document) necessary for Plan administration by Electronic Media, the Plan Sponsor will:

(1) Implement reasonable and appropriate safeguards for electronic PHI created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the group health plan;
(2) Ensure that electronic "firewalls" are in place to secure the electronic PHI;
(3) Ensure that all agents and subcontractors with access to electronic PHI comply with the security requirements; and
(4) Report to the group health plan any security incident of which it becomes aware.

Newborns' Act Disclosure

This Plan does not 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. 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). Additional information including State Rights required are described in detail in the applicable Benefit Plan Descriptions.

Notice of Rights Under the Women's Health and Cancer Rights Act (WHCRA)

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:

(1) All stages of reconstruction of the breast on which the mastectomy was performed;
(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) Prostheses; and,
(4) Treatment of physical complications of the mastectomy, including lymph edemas.

These benefits will be provided subject to the same deductible and co-insurance particulars that are applicable to other medical and surgical benefits provided under this Plan. Kier Construction Corporation has provided the detailed information regarding deductible and co-insurance for the Kier Construction Corporation Group Health Plan. For more information or to get a copy of the Summary Plan Description containing these details contact your Plan Sponsor Representative.

The Genetic Nondiscrimination Act of 2008 (GINA)

GINA prohibits a group health plan from adjusting group premium or contribution amounts for a group of similarly situated individuals based on the genetic information of members of the group. GINA prohibits a group health plan from requesting or requiring an individual or a family member of an individual to undergo genetic tests. Genetic information means information about an individual's genetic tests, the genetic tests of family members of the individual, the manifestation of a disease or disorder in family members of the individual or any request for or receipt of genetic services, or participation in clinical research that includes genetic services by the individual or a family member of the individual. The term genetic information includes, with respect to a pregnant woman (or a family member of a pregnant woman) genetic information about the fetus and with respect to an individual using assisted reproductive technology, genetic information about the embryo. Genetic information does not include information about the sex or age of any individual.

Compliance with Applicable Laws

The Plan Sponsor will administer the Benefit Plans in compliance with federal and state laws. Any interpretation of this document or the Benefit Plan Description incorporated by reference that is prohibited by federal or state law is void and will not be relied on for the administration of this Plan. The Plan Sponsor will administer the Benefit Plans in compliance with:

(1) The Mental Health Parity Act (MHPA) and The Mental Health Parity and Addiction Equity Act (MHPAEA) ERISA § 712, requiring parity in certain mental health and substance use disorder benefits;
(2) The Women's Health and Cancer Rights Act of 1998 (WHCRA) ERISA § 713(a), imposing requirements for coverage of reconstructive surgery and other complications in connection with mastectomy;
(3) ERISA § 609(c) coverage for adopted children;
(4) ERISA § 609(d) coverage of costs of pediatric vaccines;
(5) The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA);
(6) The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (applies to any group health plan sponsored by the Plan Sponsor);
(7) The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA);
(8) The Genetic Information Nondiscrimination Act (GINA);
(9) The Health Information Technology for Economic and Clinical Health Act (HITECH);
(10) Michelle's Law; and,
(11) The Family and Medical Leave Act of 1993 (FMLA).

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage under the Kier Construction Corporation Group Health Plan, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for Plan Sponsor -sponsored health coverage, but need assistance in paying their health premiums If you or your dependents are already enrolled in Medicaid or CHIP, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for a Plan Sponsor -sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your Plan Sponsor's health plan is required to permit you and your dependents to enroll in the plan as long as you and your dependents are eligible, but not already enrolled in the Plan Sponsor's plan. This is called a "special enrollment"

Summary of Plan Benefits

The Plan provides eligible employees and their eligible dependents with health insurance. These benefits are provided under the Group Insurance Contract with **Tall Tree Administrators, Sun Life Assurance Company of Canada, Standard Insurance Company, Colonial Life Insurance Company, American Family Life Assurance Company and Wasatch Employee Benefit Services.** A summary of the benefits provided under the Plan is in the Certificate of Coverage issued by **Tall Tree Administrators, Sun Life Assurance Company of Canada, Standard Insurance Company, Colonial Life Insurance Company, American Family Life Assurance Company and Wasatch Employee Benefit Services.**

The Plan, through the Group Insurance Contract, provides benefits in accordance with the applicable requirements of federal laws, such as Employee Retirement Income Security Act (ERISA), Consolidated Omnibus Budget Reconciliation Act (COBRA), Health Insurance Portability Accountability Act (HIPAA), Newborns' and Mothers' Health Protection Act (NMHPA), Mental Health Parity Act (MHPA), and the Women's Health and Cancer Rights Act (WHCRA).

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discriminating among them.

The Plan is both self-funded and fully insured. Benefits are provided under the Group Insurance Contract entered into between the Employer and **Tall Tree Administrators, Sun Life Assurance Company of Canada, Standard Insurance Company, Colonial Life Insurance Company, American Family Life Assurance Company and Wasatch Employee Benefit Services** claims for benefits are sent to the Insurance carrier, not the Employer, and is responsible for paying them. The Insurance carriers are also responsible for determining eligibility for and the amount of any benefits payable under the Plan and prescribing claims procedures and forms to be followed to receive Plan benefits. The Insurance carriers also has the discretionary authority to require participants to furnish it with such information as it determines is necessary for the proper administration of claims for Plan benefits.

Claims and Appeals

Tall Tree Administrators, Sun Life Assurance Company of Canada, Standard Insurance Company, Colonial Life Insurance, American Family Life Assurance Company and Wasatch Employee Benefit Services are responsible for evaluating all benefit claims under the Plan. The Insurers will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. If your claim is denied, you may appeal to the Insurers for a review of the denied claim and they will decide your appeal in accordance with its reasonable procedures, as required by ERISA. See the Certificate of Coverage for complete details regarding the Insurers claims and appeals procedures.

Amendment or Termination of the Plan

As Plan Sponsor, the Employer has the right to amend or terminate the Plan at any time. You have no vested or permanent rights or benefits under the Plan. Plan benefits will typically change from year-to-year and you should examine the SPD provided to you each year to determine the benefits of the Plan.

No Contract of Employment

The Plan is not intended to, and does not, either directly or indirectly constitute any form of employment contract or other employment arrangement between you and Employer.

Other Materials

The Certificate of Coverage (including the Member Payment Summary, and the Provider & Facility Directory) issued by the Insurers are part of the Summary Plan Description. Please refer to these materials for other important provisions regarding your participation in the Plan.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all group health plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, free of charge, from a group health plan or a health insurance issuer when you lose coverage under a group health plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.