

# benefit guide



**2026-2027**



**KenCrest**  
Your Dreams. Our Mission.

## 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.

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**IN THE FOLLOWING PAGES, YOU WILL FIND A SUMMARY OF OUR BENEFIT PLANS FOR THE 2026-2027 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.

This document is an outline of the coverage provided under your employer’s benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the “plan documents”). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer’s benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/ Benefits Department.

## 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 (and some positions where full time is 24 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. (Note: some nurses have no waiting period and are effective the first of the month following the hire date).

### 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 (includes same sex. 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. They do not need to reside with you to be eligible for medical, dental, and vision.
- » 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, dental, and vision, 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 four comprehensive medical / prescription drug plan options through Aetna: Two Qualified High Deductible Health Plans (HDHP), one POS plan, 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 are eligible for a contribution from KenCrest toward the cost of the coverage.

### AETNA CHOICE POS II HIGH DEDUCTIBLE HEALTH PLANS

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.

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 expenses (unless on the preventive list) 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 90% on the 2000 plan and 80% on the 4000 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 4000, the family deductible is \$8,000. The family deductible is a cumulative deductible for all family members. The family deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the \$4,000 deductible.
- » If you cover yourself and your eligible dependents under the HDHP 2000, the family deductible is \$4,000. Once the family deductible is met, all family members will be considered as having met their deductible. There is no individual deductible to satisfy within the family deductible.
- » 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 OPEN ACCESS SELECT 40 (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 Open Access Select 40 plan has a \$250 per member/\$500 per family maximum 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 Open Access Select 40 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 CHOICE POS 25

Aetna's Choice POS 25 plan is an open access plan and does not require referrals. The Aetna Choice POS 25 plan has a \$250 per member/\$500 per family maximum deductible that applies to all brand medications.

The Choice POS 25 plan uses Aetna's Choice POS II network. This includes out-of-network coverage should you need to seek treatment or services from providers that are not local or do 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
- » Breast feeding 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](https://www.cvs.com/HealthHUB) for more info!



## CVS VIRTUAL CARE

KenCrest offers telehealth services through CVS Virtual Care. Some of the main features and benefits of CVS Virtual Care 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.

Once you are set up, a CVS Virtual Care doctor is always just a click away at [www.cvs.com/virtual-care/](http://www.cvs.com/virtual-care/)

## AETNA BACK AND JOINT CARE THROUGH HINGE HEALTH

KenCrest's medical plan partners with Hinge Health to provide you and your dependents with back and joint health benefits at no additional cost. Musculoskeletal (MSK) issues are widespread and debilitating. This program provides non-surgical solutions to treat these conditions.

### **MANAGE CHRONIC BACK AND JOINT PAIN WITH HINGE HEALTH**

Digital exercise therapy can help with chronic back and joint pain. Digital therapy:

- » Employs a 12-week program delivered via tablet and sensors
- » Offers support with one-on-one health coaching and a physical therapist
- » Provides more ease-of-use and engagement compared to in-person office therapy

### **ENGAGE WITH A PHYSICAL THERAPIST VIRTUALLY FOR MORE RECENT MSK ISSUES**

- » Help alleviate acute musculoskeletal pain
- » Get up to six virtual visits with a Hinge Health physical therapist
- » Access our exercise therapy program via app

### **AVOID COMMON MSK CONDITIONS THROUGH OUR WELLNESS PROGRAM**

Our program is a customized digital solution. It can help prevent common job-related MSK conditions. Program offerings:

- » Solutions developed and delivered through the Hinge Health app
- » Features guided exercises and stretches to ease physical strain
- » Provides individually tailored programs based upon your job and level of fitness

To learn more: Visit the Aetna Back and Joint Care Support Center

[www.hingehealth.com/find/aetna](http://www.hingehealth.com/find/aetna)

## 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.

### SPECIALTY MEDICATIONS WITH PRUDENTRX

KenCrest's health plan partners with PrudentRx to offer you and your dependents a program that reduces your out-of-pocket responsibility to \$0 for your covered specialty medications under the PrudentRx Copay Program.

If you currently take one or more specialty medications and are in a plan that is part of the PrudentRx program, you are automatically enrolled into the PrudentRx program. If you are taking a specialty medication that has a copay assistance program, you must call PrudentRx to enroll in the manufacturer assistance program to get your specialty medications for a \$0 out-of-pocket cost. Call PrudentRx today at [1.800.578.4403](tel:1.800.578.4403) to start saving now.



## Medical & Prescription Plan Options

	AETNA CHOICE POS HDHP 2000		AETNA CHOICE POS HDHP 4000	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Annual Deductible</b>	Individual: \$2,000 Family: \$4,000	Individual: \$5,000 Family: \$10,000	Individual: \$4,000 Family: \$8,000	Individual: \$5,000 Family: \$10,000
<b>Out-of-Pocket Maximum</b>	Individual: \$5,600 Family: \$11,200	Individual: \$10,000 Family: \$20,000	Individual: \$5,600 Family: \$11,200	Individual: \$10,000 Family: \$20,000
<b>PCP Selection Required?</b>	No	No	No	No
<b>Referrals Required?</b>	No	No	No	No
<b>Coinsurance applies after deductible is satisfied</b>				
<b>Primary Care Office Visit (PCP)</b>	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
<b>Specialist Office Visit</b>	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
<b>Nutritional Counseling</b> (up to 10 visits per year)	0% coinsurance, no deductible applies	Not covered	0% coinsurance, no deductible applies	Not covered
<b>Diagnostics</b> (x-ray, blood work)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
<b>Imaging</b> (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
<b>Urgent Care</b>	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
<b>Emergency Room</b>	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
<b>Inpatient Hospital Stay</b>	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
<b>Outpatient Surgery</b>	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
<b>Routine Vision Exam</b>	Not covered	Not covered	Not covered	Not covered
<b>Prescription Drug: Retail (30 day supply)*</b>				
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	
<b>Mail Order (90-day supply)</b>				
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	

\*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.

### MEDICAL AND PRESCRIPTION DRUG COVERAGE: MONTHLY PLAN DEDUCTIONS

	AETNA CHOICE POS HDHP 2000		AETNA CHOICE POS HDHP 4000*	
	Part-Time Cost	Full-Time Cost	Part-Time Cost	Full-Time Cost
<b>Single</b>	\$1,161.29	\$161.29	\$982.80	\$0.00
<b>Employee &amp; Spouse</b>	\$2,340.85	\$1,340.85	\$1,690.66	\$690.66
<b>Employee &amp; Child(ren)</b>	\$1,255.80	\$250.00	\$1,201.20	\$200.00
<b>Employee &amp; Family</b>	\$2,792.34	\$1,792.34	\$1,909.06	\$909.06

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

	AETNA CHOICE OPEN ACCESS SELECT 40		AETNA CHOICE POS 25 PLAN	
	In-Network*	In-Network*	In-Network*	Out-of-Network
<b>Annual Medical Deductible</b>	Individual: \$0 Family: \$0	Individual: \$0 Family: \$0	Individual: \$1,500 Family: \$4,500	
<b>Annual Prescription Deductible</b> (Deductible does not apply to generic medications or diabetic supplies)	Individual: \$250 Family: \$250 per member to a max of \$500 per family	Individual: \$250 Family: \$250 per member to a max of \$500 per family	Individual: \$250 Family: \$250 per member to a max of \$500 per family	
<b>Out-of-Pocket Maximum</b>	Individual: \$3,000 Family: \$6,000	Individual: \$3,000 Family: \$6,000	Individual: \$10,000 Family: \$30,000	
<b>PCP Selection Required?</b>	No	No	No	
<b>Referrals Required?</b>	No	No	No	
<b>Coinsurance applies after deductible is satisfied</b>				
<b>Primary Care Office Visit (PCP)</b>	\$40 copay	\$25 copay	50% coinsurance	
<b>Specialist Office Visit</b>	\$60 copay	\$40 copay	50% coinsurance	
<b>Nutritional Counseling</b> (up to 10 visits per year)	0% coinsurance	0% coinsurance	Not covered	
<b>Diagnostics</b> (x-ray, blood work)	Lab: No charge X-ray: \$60 copay	Lab: No charge X-ray: \$40 copay	50% coinsurance	
<b>Imaging</b> (CT/PET scans, MRIs)	\$100 copay	\$80 copay	50% coinsurance	
<b>Urgent Care</b>	\$85 copay	\$70 copay	50% coinsurance	
<b>Emergency Room</b>	\$200 copay	\$200 copay	\$200 copay	
<b>Inpatient Hospital Stay*</b>	\$1,500 per stay	\$1,500 per stay	50% coinsurance	
<b>Outpatient Surgery</b>	\$500 copay	\$250 copay	50% coinsurance	
<b>Routine Vision Exam</b>	Not covered	Not covered	Not covered	
<b>Prescription Drug: Retail (30 day supply)**</b>				
Generic Formulary	\$20	\$20	Not covered	
Brand Formulary	\$40 after Rx deductible	\$40 after Rx deductible		
Brand Non-Formulary	\$70 after Rx deductible	\$70 after Rx deductible		
<b>Mail Order (90-day supply)</b>				
Generic Formulary	\$40	\$40	Not covered	
Brand Formulary	\$80 after Rx deductible	\$80 after Rx deductible		
Brand Non-Formulary	\$140 after Rx deductible	\$140 after Rx deductible		

\*The copay for inpatient hospital stays at in-network facilities is paid for by KenCrest.

\*\*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.

Every year on July 1, you owe the individual brand Rx deductible of \$250 per member to a max of \$500 per family. All generic medications have a \$0 deductible and will be a \$20 copay. Deductible does not apply to diabetic supplies, the appropriate copays will apply. All brand medications have a \$40 or \$70 copay after you have met the individual deductible.

### MEDICAL AND PRESCRIPTION DRUG COVERAGE: MONTHLY PLAN DEDUCTIONS

	AETNA CHOICE OPEN ACCESS SELECT 40		AETNA CHOICE POS 25 PLAN	
	Part-Time Cost	Full-Time Cost	Part-Time Cost	Full-Time Cost
<b>Single</b>	\$1,325.68	\$325.68	\$1,567.71	\$567.71
<b>Employee &amp; Spouse</b>	\$3,025.23	\$2,025.23	\$3,712.47	\$2,712.47
<b>Employee &amp; Child(ren)</b>	\$2,320.50	\$1,320.50	\$2,432.85	\$1,432.85
<b>Employee &amp; Family</b>	\$3,925.29	\$2,925.29	\$4,841.81	\$3,841.81

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)

Administered by KenCrest

**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. Official documentation indicating loss of coverage may be requested as proof.

KenCrest offers two High Deductible 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.

It is highly encouraged that you add your own pre-tax dollars into a HSA. With both plans, you can start, stop or modify your contributions in Workday at any time, not just at 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

The annual maximum that may be deposited into a Health Savings Account in 2026 is:

- » \$4,400 for employee only
- » \$8,750 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.

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 \$1,000 in your account, you have the opportunity to move your money into mutual fund investments. Certain charges and restrictions may apply.



## AblePay: Savings & Payment Program

Administered by KenCrest

KenCrest offers AblePay to all employees. This is a no-cost program that provides savings of up to 13% and can help you if you have questions and concerns about a medical bill. It provides flexible payment terms for billed out-of-pocket medical expenses as well as the convenience of paying medical bills through an online portal.

This program is designed to advocate for employees through personalized customer service and ease of use. The user friendly member portal makes it easy to make payments and provides simplified invoicing. For example, if you have a \$1,000 medical bill and choose the 13% savings, you will owe AblePay \$870. AblePay pays the provider the negotiated amount, and the full \$1,000 goes towards your deductible. You can also tie your FSA or HSA card to further stretch these funds!\*

To get started with AblePay, visit the website <https://enroll.ablepayhealth.com/apply/AJG2026> and click “Enroll Now.” Enter your demographic information and list “KenCrest” as your employer. You may also add family members that you’ll be responsible for, even if they have a different health insurance plan. After you add your default payment term and payment method(s), you can expect to receive your AblePay card in the mail. Keep this card with your insurance card.

\*Must use with a participating provider. Participating providers include Main Line Health, Penn Medicine, Grand View Health, Lehigh Valley Health Network, Penn State Health, St. Luke’s University Health Network, and more. AblePay may also be able to get discounts for members at non-contracted providers.



## Dental Benefits



Administered by Aetna

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. The network is very small, so we advise that you check for a provider that is in-network before enrolling. There are no DMO providers in southern Delaware (Dover area). 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 nationwide 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.

	DMO	Value PPO	PPO
	In-Network Only	In & Out-of-Network	In & Out-of-Network
<b>Annual Deductible</b>	None	Individual: \$50 / Family: \$150	Individual: \$50 / Family: \$150
<b>Preventive Care</b> (Periodontics, Endodontics, Oral Surgery)	Copay varies	100%*	100%*
<b>Basic Services</b>	Copay varies	70%	80%
<b>Major Services</b>	Copay varies	Not covered	50%
<b>Annual Maximum Benefit</b>	Unlimited	\$1,500*	\$1,500*
<b>Orthodontics Services</b>	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
<b>Employee</b>	\$17.83	\$26.76	\$40.26
<b>Employee + 1</b>	\$36.38	\$48.70	\$84.57
<b>Employee + 2 or more</b>	\$53.92	\$81.53	\$120.39

\*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.

## New Voluntary Vision Plan

Administered by VBA

We are pleased to introduce a new, stand-alone voluntary vision benefit effective **July 1, 2026**, provided by VBA. This plan allows employees to enroll themselves and eligible dependents for coverage. The vision plan provides access to a broad network of in-network VBA providers, including many local optometrists and ophthalmologists. To find an in-network VBA provider near you, employees can use VBA's online Provider Finder by visiting [VBAPlans.com](http://VBAPlans.com) and selecting "Looking for a provider near you" at the bottom of the page.

### ADDITIONAL VISION & HEARING SAVINGS

Enrollment in the VBA vision plan also provides access to valuable discounts beyond routine eye care. Members are eligible for LASIK savings, including up to \$1,100 in savings at partner LASIK providers Quallsight LASIK and TLC Laser Eye Centers. In addition, enrollment includes up to 40% savings on hearing aids and hearing aid evaluations, helping make hearing care more affordable for you and your family. These added discounts are included simply by signing up for the vision plan.

Last Date of Service	Employee	Spouse	Children
<b>Vision Exam</b>	12 Months	12 Months	12 Months
<b>Lenses</b>	12 Months	12 Months	12 Months
<b>Frames</b>	12 Months	12 Months	12 Months

Benefits: Employee Can Select Either	VBA Participating Provider Amount Covered/Benefit (After Applicable Copay)*	Out-of-Network Max Reimbursement (Zero Copay)
<b>Vision Exam</b> (Glasses or Contacts)	Covered in Full	\$40
<b>Retinal Screening with Exam</b>	Copay not to exceed \$39	N/A

#### Clear Standard Lenses (Pair):

<b>Single Vision</b>	Covered in Full	\$40
<b>Bifocal</b>	Covered in Full	\$60
<b>Blended Bifocal</b>	Covered in Full	\$60
<b>Trifocal</b>	Covered in Full	\$80
<b>Progressives</b> (Basic)	Covered in Full	\$80
<b>Progressives</b> (Standard and Premium 1-4)	Partially-Covered	\$80
<b>Lenticular</b>	Covered in Full	\$120
<b>Polycarbonate</b>	Covered in Full for Persons Up to Age 19	N/A
<b>Basic Scratch Coating</b>	Covered in Full	N/A
<b>Frame</b>	Up to \$200	\$50

#### -AND-

<b>Elective Contacts</b>		
<b>Material Allowance</b>	Up to \$200 <sup>A</sup>	\$200
<b>Elective Fitting Fee and Evaluation</b>	15% off UCR	N/A

#### -OR-

<b>Medically Necessary Contacts</b>	Covered in Full <sup>A</sup>	\$450
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#### -AND-

<b>Lasik Surgery</b> (once every 8 years)	N/A	\$125
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Monthly Vision Premium Amount	
<b>Employee</b>	\$7.35
<b>Employee + Spouse</b>	\$13.95
<b>Employee + Child(ren)</b>	\$14.32
<b>Employee + Family</b>	\$19.09

Where an "allowance" is shown above, the Member is responsible for paying any charges in excess of the allowance less any applicable copay.

Benefits and participation may vary by location, including, but not limited to, Costco® Optical, Pearle Vision, LensCrafters®, Target Optical®, Eyeglass World®, America's Best® and Boscov's™ Optical.

<sup>A</sup> The allowance is applied to all services/materials associated with contact lenses, including, but not limited to, contact fitting, dispensing, cost of the lenses, etc. No guarantee the allowance will cover the entire cost of services and materials.

<sup>B</sup> Requires prior approval. May only be selected in lieu of all other material benefits listed herein.

\* A \$10 copayment is applied to the vision exam and a \$25 copayment is applied to the total cost of the lenses and/or frames ordered from a VBA Member Doctor only. Copayments do not apply to the contact materials.

## New Voluntary Vision Plan

### PLAN DESIGN:

This plan is designed to cover your visual needs rather than cosmetic options.

### ADDITIONAL CHARGES:

- » You may incur out-of-pocket charges when selecting any of the following:
- » Tinted Lenses
- » Photochromic/Polarized Lenses
- » Polycarbonate (covered under age 19)
- » Hi-index Lenses
- » Progressive (available starting at \$29)
- » The coating of the lens or lenses (except Basic Scratch Coating)
- » A frame that costs more than the plan allowance
- » Rimless Frames
- » Anti-Reflective

Additionally, costs for contact lenses/services in excess of the plan's scheduled reimbursement allowances are the responsibility of the patient.

### NOT COVERED:

The contract gives VBA the right to waive any of the plan limitations if, in the opinion of our optometric consultants, it is necessary for the patient's welfare. VBA provides no benefit for professional services or materials connected with the following:

- » Orthoptics or vision training
- » Non-prescription lenses
- » Two pair of glasses in lieu of bifocals
- » Medical or surgical treatment of the eyes
- » An eye examination, or corrective eyewear, required by an employer as a condition of employment
- » Services of materials provided as result of any Worker's Compensation Law or similar legislation

Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.

### ADDITIONAL TERMS AND CONDITIONS:

Elective contact lens benefits may be selected in addition to the spectacle lens and frame benefits covered by your plan. If purchased at the same time from a single provider, your plan will cover up to \$200 towards the cost of contact fitting fees and contact lenses. Any provider charges that exceed this amount shall be the responsibility of the member. Members may be required to pay contact fitting fees out of pocket at some locations.

- » Benefits and participation may vary by location and where prohibited by state law.
- » LASIK benefits may be limited to no more than 50% per eye.
- » Exam copay is not required if benefits are used to purchase contact lenses from a single provider on the same day of the member's exam. Material copays do not apply to contact lenses.
- » A 15% discount off the provider's usual, customary and reasonable contact lens fitting fee may be available in some locations. Void where prohibited by law.
- » Benefits may only be used for medically necessary contact lenses when selected in lieu of all other materials.

## Flexible Spending Account (FSA)

Administered by American Benefits Group

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 for eligible health and dependent care expenses. The IRS requires American Benefits Group to validate all transactions to ensure that they are eligible. You may be required to provide proof of purchase to American Benefits Group upon request.

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, 2026 to June 30, 2027).



### 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 for 2026 is \$3,400; 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.” A Limited Purpose FSA is used only to gain an additional tax advantage if you have put aside the maximum amount in your HSA. Limited Purpose FSAs may only be used for dental, vision, and hearing expenses.

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.

### TRANSIT

Through payroll deduction you can use tax-free dollars to purchase tokens, tickets or passes for your commute by train, bus, subway, or vanpools. The commuter benefit may be used at participating transit operations such as SEPTA, NJ Transit, PATCO, DART and Amtrak. This is not a reimbursement account - you will receive a debit card to use your transit benefits. If funds are unused they roll forward from month to month and year to year.

### 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 overnight care.

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

- » \$7,500 for a married couple filing jointly / single parent
- » \$3,750 for a married person filing separately



In 2026, maximum amount you may defer for transit is \$340 per month from your pay for this benefit.

## 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 \$20,000 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
<b>Basic Life and AD&amp;D</b>	\$20,000	\$20,000	N/A
<b>Voluntary Supplemental Life</b>			
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 \$10,000	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, 2026.

## Voluntary 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



## 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 Corebridge Financial Advisor:** Barbara Bauer: **267.606.5194** or [Barbara.Bauer@CorebridgeFinancial.com](mailto:Barbara.Bauer@CorebridgeFinancial.com)

**YOUR ADDITIONAL COREBRIDGE FINANCIAL ADVISORS:**

Maria Deysher: **215.444.3872** or [Maria.Deysher@CorebridgeFinancial.com](mailto:Maria.Deysher@CorebridgeFinancial.com)

Emily Spych: **267.780.3438** or [Emily.Spych@CorebridgeFinancial.com](mailto:Emily.Spych@CorebridgeFinancial.com)

George Bivolarski: **203.919.7561** or [George.Bivolarski@CorebridgeFinancial.com](mailto:George.Bivolarski@CorebridgeFinancial.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 change or stop your contributions to the 403(b) plan at any time. All changes, including resuming contributions, can be done by you in Workday.

### 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.

Please note that once you become eligible for the KenCrest match, even if you reduce hours, the match will continue as long as 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.

## 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 Corebridge Financial representative to enroll in the plan and choose the best investment vehicles for you.

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



## Additional Voluntary Benefits

Click [here](#) to review the Additional Voluntary Benefits before you make your election.

### Voluntary Hospital Plan

Administered by UNUM

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 \$1,250 for two hospital stays per coverage year PLUS
- » \$100 per day for up to 365 days of inpatient hospital stay during the coverage year

This benefit can be used whether you whether you have the Open Access Select 40 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.

#### **BE WELL BENEFIT**

Employees have a health screening benefit that 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).

#### **HOSPITAL PLAN RATES**

	Monthly Rates
<b>Employee</b>	\$17.99
<b>Employee + Spouse</b>	\$33.90
<b>Employee + Child(ren)</b>	\$23.93
<b>Employee + Family</b>	\$39.84



## Voluntary Accident Plan

Administered by UNUM

Accident insurance pays a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on or off the job. And it includes a range of incidents, from common injuries to more serious events.

This benefit can help you and your family with out-of-pocket costs that your medical plan doesn't cover, such as copays and deductibles.

**Please refer to the Employee Portal or [www.enrollvb.com/kencrest](http://www.enrollvb.com/kencrest) and check out the Accident Insurance Flyer to see a full list of covered injuries.**

### BE WELL BENEFIT

Employees have a health screening benefit that 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).

### ACCIDENT PLAN RATES

	Monthly Rates
Employee	\$16.14
Employee + Spouse	\$26.67
Employee + Child(ren)	\$29.03
Employee + Family	\$39.56



## CRITICAL ILLNESS INSURANCE

Administered by Unum

### 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. The chart below details what is covered under the critical illness insurance plan:

	Diagnosis	Percent of Benefit Amount
<b>Critical Illnesses</b>	End Stage Renal (Kidney) Failure	100%
	Heart Attack (Myocardial Infarction)	100%
	Major Organ Failure Requiring Transplant	100%
	Stroke	100%
	Sudden Cardiac Arrest	100%
	Coronary Artery Disease (Major)	50%
	Coronary Artery Disease (Minor)	10%
<b>Cancer</b>	Invasive Cancer (including all Breast Cancer)	100%
	Non-Invasive Cancer	25%
	Skin Cancer	\$500
<b>Supplemental Critical Illnesses</b>	Benign Brain Tumor	100%
	Coma	100%
	Loss of Hearing	100%
	Loss of Sight	100%
	Loss of Speech	100%
	Permanent Paralysis	100%
	Bone Marrow/Stem Cell Transplant	25%
	Infectious Disease	25%
	Pulmonary Embolism	25%
	Transient Ischemic Attack (TIA)	25%
<b>Progressive Diseases</b>	Addison's Disease	100%
	Amyotrophic Lateral Sclerosis (ALS)	100%
	Dementia (including Alzheimer's Disease)	100%
	Huntington's Disease	100%
	Lupus	100%
	Multiple Sclerosis	100%
	Muscular Dystrophy	100%
	Myasthenia Gravis	100%
Parkinson's Disease	100%	
Systemic Sclerosis (Scleroderma)	100%	

### WHO CAN GET COVERAGE?

**You:** Choose from coverage options of \$10,000, \$20,000, or \$30,000

**Your Spouse:** Spouses can get coverage for 100% of the employee coverage amount, as long as you have purchased coverage for yourself

**Your Child(ren):** Children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 100% of yours

### BE WELL BENEFIT

Employees have a health screening benefit that 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).

## INTEREST-SENSITIVE WHOLE LIFE INSURANCE (ADMINISTERED BY UNUM)

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.

**Note: Enrollment in Whole Life Insurance can only be done on the enrollvb platform, not through Workday. Visit this custom enrollment link to make your elections:**  
[www.enrollvb.com/kencrest](http://www.enrollvb.com/kencrest)

## Pet Insurance

Administered by MetLife

MetLife Pet Insurance offers reimbursement on accidents and illnesses, including office visits and prescription medications for cats or dogs. You have the flexibility to select various levels of coverage and can include multiple pets on one policy. This coverage also includes a \$50 Healthy Pet Incentive that automatically reduces your deductible each policy year that you do not receive a claim reimbursement.

Value Add Services include:

- » Virtual vet concierge services
- » Loss due to theft or straying
- » Grief counseling for loss of pet
- » Cremation, burial, and mortality benefits

Pricing is individually quoted based on age, breed, and location of your pet. Discounts are available for Internet purchasers, military, veterans, first responders, healthcare workers, and animal care workers.

The Pet Insurance benefit is a benefit that you elect online due to the customization of the program based on your pet's breed and age. Use the link below to obtain a quote, enroll, and pay for the coverage.

[www.metlife.com/getpetquote](http://www.metlife.com/getpetquote)



## EMPLOYEE ASSISTANCE PROGRAM

**LIFE COMES WITH CHALLENGES.**

AllOne Health is here to help.

Your EAP with AllOne can help you reduce stress, improve mental health, and make life easier by connecting you to the right information, resources, and referrals.

**All services are free, confidential, and available to you and your family members.**

This includes access to short-term counseling and the wide range of services listed below:



**6 Mental Health Sessions**



**Life Coaching**



**Financial Consultation**



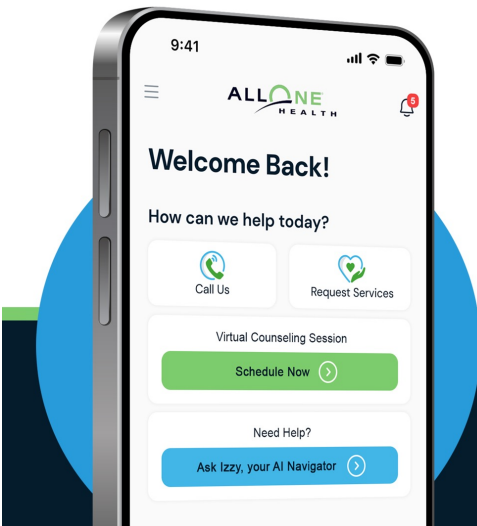
**Legal Referrals**



**Work-Life Resources**



**Medical Advocacy**



## Unlimited Resources, Always Available

Access your benefits 24/7/365 through your member portal or the AllOne Health app with online requests and chat options. Explore thousands of self-help tools and resources including articles, assessments, podcasts, and resource locators.

**Contact AllOne Health**  
**Call: 800-451-1834**

Visit: [allonehealth.com/portal](http://allonehealth.com/portal) Access Code: 3AC8A

### ALLSTATE IDENTITY PROTECTION

KenCrest offers all employees the opportunity to elect identity protection coverage with AllState.

AllState Identity Protection delivers comprehensive fraud monitoring and powerful mobile and desktop cybersecurity to help you protect yourself, your family, and your finances from emerging threats. See and manage your personal data, safeguard your devices, and protect your identity.

If fraud occurs, you can rely on our full service restoration, plus up to \$1 million in fraud expense reimbursement (\$2 million for families) to cover stolen funds or out-of-pocket costs. For more information, please refer to the Employee Portal of the KenCrest website on the Human Resources page.

#### ALLSTATE IDENTITY PROTECTION RATES

	Monthly Rates
<b>Individual:</b>	\$6.50
<b>Family:</b>	\$14.50

### 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 Portal). 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 Portal of the KenCrest website on the Human Resources page. 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.

### 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.

The application and program guidelines can be found on the Employee Portal of the KenCrest website on the Human Resources page.



## Important Legal Notices

### PATIENT PROTECTIONS DISCLOSURE

The KenCrest Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Aetna at **800.962.6842**.

### WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Please reference the plan designs within this guide

If you would like more information on WHCRA benefits, please call your Plan Administrator at **610.825.9360**, [ksmith@KenCrest.org](mailto:ksmith@KenCrest.org).

### NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## 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](http://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 **877.KIDS.NOW** or [www.insurekidsnow.gov](http://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](http://www.askebsa.dol.gov) or call **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, 2026. Contact your state for more information on eligibility.**

### ALABAMA – Medicaid

<http://myalhipp.com>  
855.692.5447

### ALASKA – Medicaid

The AK Health Insurance Premium Payment Program  
<http://myakhipp.com/> | 866.251.4861  
CustomerService@MyAKHIPP.com  
Medicaid Eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

### ARKANSAS – Medicaid

<http://myarhipp.com>  
855.MyARHIPP (855.692.7447)

### CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program  
<http://dhcs.ca.gov/hipp>  
916.445.8322 | Fax: 916.440.5676 | Email: [hipp@dhcs.ca.gov](mailto:hipp@dhcs.ca.gov)

### COLORADO – Medicaid and CHIP

Health First Colorado (Colorado's Medicaid Program)  
<https://www.healthfirstcolorado.com>  
Member Contact Center: 800.221.3943 | State Relay 711  
Child Health Plan Plus (CHP+)  
<https://hcpf.colorado.gov/child-health-plan-plus>  
Customer Service: 800.359.1991 | State Relay 711  
Health Insurance Buy-In Program (HIBI)  
<https://www.mycohibi.com/>  
HIBI Customer Service: 855.692.6442

### FLORIDA – Medicaid

[www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html](http://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html)  
877.357.3268

### GEORGIA – Medicaid

GA HIPP: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>  
678.564.1162, Press 1  
GA CHIPRA: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra> 678.564.1162, Press 2

### INDIANA – Medicaid

Health Insurance Premium Payment Program  
All other Medicaid  
<https://www.in.gov/medicaid/> | 800.457.4584  
Family and Social Services Administration  
<http://www.in.gov/fssa/dfr/> | 800.403.0864

### IOWA – Medicaid and CHIP (Hawki)

Medicaid: <https://hhs.iowa.gov/programs/welcome-iowa-medicaid>  
800.338.8366  
Hawki: <https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki>  
800.257.8563  
HIPP: <https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp>  
888.346.9562

### KANSAS – Medicaid

<https://www.kancare.ks.gov/>  
800.792.4884 | HIPP Phone: 800.967.4660

### KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP):  
<https://chfs.ky.gov/agencies/dms/member/Pages/kihhipp.aspx>  
855.459.6328 | KIHIPP@ky.gov  
KCHIP: <https://kynect.ky.gov/> | 877.524.4718  
Medicaid: <https://chfs.ky.gov/agencies/dms>

### LOUISIANA – Medicaid

Medicaid: [www.ldh.la.gov/healthy-louisiana](http://www.ldh.la.gov/healthy-louisiana)  
Customer Service Line: 888.342.6207  
Medicaid Email: [healthy@la.gov](mailto:healthy@la.gov)  
Louisiana Health Insurance Premium Program (LaHIPP):  
<https://www.ldh.la.gov/lahipp>  
LaHIPP Phone: 877.697.6703 | LaHIPP Email: [La.HIPP@la.gov](mailto:La.HIPP@la.gov)  
LaHIPP Fax: 888.716.9787  
LaHIPP Mailing Address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

### MAINE – Medicaid

Enrollment: [https://www.mymaineconnection.gov/benefits/s/?language=en\\_US](https://www.mymaineconnection.gov/benefits/s/?language=en_US)  
800.442.6003 | TTY: Maine relay 711  
Private Health Insurance Premium:  
<https://www.maine.gov/dhhs/ofl/applications-forms>  
800.977.6740 | TTY: Maine relay 711

#### MASSACHUSETTS – Medicaid and CHIP

<https://www.mass.gov/masshealth/pa>  
800.862.4840 | TTY: 711 | Email: [masspreassistance@accenture.com](mailto:masspreassistance@accenture.com)

#### MINNESOTA – Medicaid

<https://mn.gov/dhs/health-care-coverage/>  
800.657.3672

#### MISSOURI – Medicaid

<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>  
573.751.2005

#### MONTANA – Medicaid

<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>  
800.694.3084 | Email: [HHSHIPProgram@mt.gov](mailto:HHSHIPProgram@mt.gov)

#### NEBRASKA – Medicaid

<http://www.ACCESSNebraska.ne.gov>  
Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178

#### NEVADA – Medicaid

<http://dhcfp.nv.gov>  
800.992.0900

#### NEW HAMPSHIRE – Medicaid

<https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>  
603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 15218 | Email: [DHHS.ThirdPartyLiabi@dhhs.nh.gov](mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov)

#### NEW JERSEY – Medicaid and CHIP

Medicaid: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid>  
800.356.1561  
CHIP: <http://www.njfamilycare.org/index.html>  
800.701.0710 (TTY: 711) | Premium Assistance: 609.631.2392

#### NEW YORK – Medicaid

[https://www.health.ny.gov/health\\_care/medicaid/](https://www.health.ny.gov/health_care/medicaid/)  
800.541.2831

#### NORTH CAROLINA – Medicaid

<https://dma.ncdhhs.gov>  
919.855.4100

#### NORTH DAKOTA – Medicaid

<https://www.hhs.nd.gov/healthcare>  
844.854.4825

#### OKLAHOMA – Medicaid and CHIP

<http://www.insureoklahoma.org>  
888.365.3742

#### OREGON – Medicaid and CHIP

<http://healthcare.oregon.gov/Pages/index.aspx>  
800.699.9075

#### PENNSYLVANIA – Medicaid and CHIP

<https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>  
800.692.7462  
CHIP Website: <https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>  
CHIP Phone: 800.986.KIDS (5437)

#### RHODE ISLAND – Medicaid and CHIP

<http://www.eohhs.ri.gov>  
855.697.4347 or 401.462.0311 (Direct Rlte Share Line)

#### SOUTH CAROLINA – Medicaid

<http://www.scdhhs.gov>  
888.549.0820

#### SOUTH DAKOTA – Medicaid

<http://dss.sd.gov>  
888.828.0059

#### TEXAS – Medicaid

<https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>  
800.440.0493

#### UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)  
<https://medicaid.utah.gov/upp/> | Email: [upp@utah.gov](mailto:upp@utah.gov) | 888.222.2542  
Adult Expansion: <https://medicaid.utah.gov/expansion/>  
Utah Medicaid Buyout Program: <https://medicaid.utah.gov/buyout-program/>  
CHIP: <https://chip.utah.gov/>

#### VERMONT – Medicaid

<https://dvha.vermont.gov/members/medicaid/hipp-program>  
800.250.8427

#### VIRGINIA – Medicaid and CHIP

<https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>  
<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>  
Medicaid and Chip: 800.432.5924

#### WASHINGTON – Medicaid

<https://www.hca.wa.gov/>  
800.562.3022

#### WEST VIRGINIA – Medicaid and CHIP

<https://dhhr.wv.gov/bms/> or <http://mywvhipp.com/>  
Medicaid: 304.558.1700  
CHIP Toll-free: 855.MyWVHIPP (855.699.8447)

#### WISCONSIN – Medicaid and CHIP

<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>  
800.362.3002

#### WYOMING – Medicaid

<https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>  
800.251.1269

**To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:**

**U.S. Department of Labor**  
Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)  
866.444.EBSA (3272)

**U.S. Department of Health and Human Services**  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://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 [ebssa.opr@dol.gov](mailto:ebssa.opr@dol.gov) and reference the OMB Control Number 1210-0137.

## HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

### Protecting Your Health Information Privacy Rights

KenCrest Services is committed to the privacy of your health information. The administrators of the KenCrest Health Plan (the “Plan”) use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan’s policies protecting your privacy rights and your rights under the law are described in the Plan’s Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Kim Smith at [610.825.9360](tel:610.825.9360), [ksmith@KenCrest.org](mailto:ksmith@KenCrest.org).

## HIPAA SPECIAL ENROLLMENT RIGHTS

### KenCrest Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the KenCrest Health Plan (to actually participate, you must complete an enrollment form and may be required to pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan – your right to enroll in the plan under its “special enrollment provision” if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

#### **Loss of Other Coverage (Excluding Medicaid or a State Children’s Health Insurance Program).**

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

**Loss of Coverage for Medicaid or a State Children’s Health Insurance Program.** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

**New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.** If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

**Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program.** If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Kim Smith at **610.825.9360**, [ksmith@KenCrest.org](mailto:ksmith@KenCrest.org).

### **Important Warning**

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

## NOTICE OF CREDITABLE COVERAGE

### Important Notice from KenCrest Services 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:**

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- 2. KenCrest Services has determined that the prescription drug coverage offered by the medical plan 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 higher premium (a penalty) if you later decide to join a Medicare drug plan.**

#### **When Can You Join a Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to 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 (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

#### **What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?**

If you decide to join a Medicare drug plan, your 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 Services and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

**For More Information About This Notice or Your Current Prescription Drug Coverage:**

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through 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](http://www.medicare.gov).
- » Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- » Call **800.MEDICARE (800.633.4227)**. TTY users should call **877.486.2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at **800.772.1213** (TTY **800.325.0778**).

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

Date: July 1st, 2026  
Name of Entity/Sender: KenCrest Services  
Contact: Kim Smith, Director of Benefits  
Address: 960A Harvest Drive, Suite 100, Blue Bell, PA 19422  
Phone Number: 610.825.9360, Ext. 1032

## MARKETPLACE NOTICE

### Health Insurance Marketplace Coverage Options and Your Health Coverage

#### **PART A: GENERAL INFORMATION**

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Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace (“Marketplace”). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

#### **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 in your geographic area.

#### **Can I Save Money on my Health Insurance Premiums in the Marketplace?**

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn’t meet certain minimum value standards (discussed below). The savings that you’re eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

#### **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 is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%<sup>1</sup> of your annual household income, or if the coverage through your employment does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee’s household income.<sup>1,2</sup>

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

#### **When Can I Enroll in Health Insurance Coverage through the Marketplace?**

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

<sup>1</sup> Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2026.

<sup>2</sup> An employer-sponsored or other employment-based health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the “minimum value standard,” the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2026, through July 31, 2026. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2026, through March 31, 2026. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2026. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by [HealthCare.gov](https://www.healthcare.gov) and either submit a new application or update an existing application on [HealthCare.gov](https://www.healthcare.gov) between March 31, 2026 and July 31, 2026, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2026, and July 31, 2026, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at **800.318.2596**. TTY users can call **855.889.4325**.

### **What about Alternatives to Marketplace Health Insurance Coverage?**

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2026 and July 10, 2026, you can request this special enrollment in the employment-based health plan through September 8, 2026. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency.

Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

### **How Can I Get More Information?**

For more information about your coverage offered through your employment, please check your health plan's 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 [HealthCare.gov](https://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.

**PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER**

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name KenCrest Services		4. Employer Identification Number (EIN) 25-1439925	
5. Employer address 960A Harvest Drive, Suite 100		6. Employer phone number <b>610.825.9360</b>	
7. City Blue Bell	8. State PA		9. ZIP code 19422
10. Who can we contact about employee health coverage at this job? Kim Smith, Human Resources			
11. Phone number (if different from above) <b>610.825.9360</b>		12. Email address <b>ksmith@kencrest.org</b>	

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

» As your employer, we offer a health plan to:

- All 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.

Some employees. Eligible employees are:

» 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).

We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**\*\*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 mid-year, or if you have other income losses, you may still qualify for a premium discount.**

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

## Contact Information

Benefit	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	VBA	memberservices@vbaplans.com	800.432.4966
Dental	Aetna	www.aetna.com	877.238.6200
Health Savings Account	Inspira	https://inspirafinancial.com/	888.678.8242
CVS Virtual Care	CVS	www.cvs.com/virtual-care/	866.211.5678
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
Transit Account	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
Accident Insurance	Unum	www.unum.com	800.635.5597
Critical Illness Insurance	Unum	www.unum.com	800.635.5597
Hospital Plan	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
Pet Insurance	MetLife	www.metlifepetinsurance.com	800.GET.MET8
Identity Protection	AllState	www.myaip.com	800.789.2720
403(b) Retirement Plan	Corebridge Financial	www.corebridgefinancial.com	800.448.2542
529 College Savings Plan	The Blackrock 529	www.blackrock/ collegeadvantage.com	866.529.8582
Employee Assistance Program (EAP)	AllOne Health	allonehealth.com Access code: 3AC8A	800.451.1834



## Notes

## Notes



*This benefit guide prepared by*



**Gallagher**

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