LCA PUBLIC ACCESS FILE

LCA validity dates: 10/1/2023 to 9/30/2026

Job title/location: Job Cost Accountant/Stockton, California

ETA case number: I-200-23131-014648

Public access documentation:

- ❑ Two notices, which have been posted in different places at the work site for 10 days
- ❑ LCA (Form ETA 9035E)
- ❑ LCA cover pages (Form ETA 9035CP)
- ❑ Memorandum establishing actual wage
- ❑ Prevailing wage documentation
- ❑ Memorandum regarding employee benefits, with copy of employer's summary benefits plan description(s) attached

NOTICE

Pursuant to Federal Regulations at 20 CFR, Part 655, and 29 CFR, Part 507, notice is hereby given that Patriot Construction, Inc. has filed a labor condition application with the U.S. Department of Labor for the employment of one H-1B nonimmigrant in the occupational classification of Job Cost Accountant. Said employment will be in Stockton, CA for a maximum period of three years, between 10/1/2023 and 9/30/2026. The H-1B wage offered for this occupation is $53,830 per year. The labor condition application is available for public inspection by inquiring with Human Resources at Patriot Construction, Inc., 4646 Qantas Lane, Ste. B-4, Stockton, CA 95206. Complaints alleging misrepresentation of material facts in the labor condition application and/or failure to comply with the terms of the labor condition application may be filed with any office of the Wage and Hour Division of the United States Department of Labor.

If a hard copy of this notice or the LCA was posted at the worksite, complete the following:

Date posted: _____ By: _____

Place posted: _____ By: _____

Date removed: _____ By: _____

If this notice or the LCA was posted electronically, complete the following:

Date posted: _____ By: _____

Place posted: _____ By: _____

Date removed: _____ By: _____

MEMORANDUM ESTABLISHING ACTUAL WAGE
FOR LABOR CONDITION APPLICATION

In determining the actual wage for the position of Job Cost Accountant at our facility located in Stockton, California, Patriot Construction, Inc. considers the following factors:

(1) Experience, including whether the candidate has been previously employed in this position, the length of any such employment, the type of employment (e.g., whether supervisory in nature), and the depth and breadth of such experience;

(2) Educational background, including the level of education obtained, the existence of special academic achievements (such as superior class rank or other distinction, and the reputation of the educational facility/ies attended;

(3) Job responsibility and function, including nature of duties and responsibilities to be performed and degree of supervision to be exercised;

(4) Possession of specialized knowledge, skills or training;

(5) Current rates of pay of other employees in the organization or group and their relative positions; and

(6) Other indicators of performance and/or ability, including job references, performance evaluations, awards, achievements and/or accomplishments.

The actual wage for the position is $53,830 per year. The H-1B candidate to whom this LCA pertains will be paid said wage, consistent with the above factors.

Periodic wage adjustments to the actual wage in question are made to reflect employee annual increases, cost-of-living adjustments, moves to a greater responsibility level, increases in entry-level pay that affect the overall salary structure.

MEMORANDUM REGARDING EMPLOYEE BENEFITS

Attached or filed with Human Resources are employee handbook excerpts, summary plan descriptions, and/or other materials that describe the benefits that Patriot Construction, Inc. offers to employees in the occupational classification of Job Cost Accountant. These materials also include statements of how employees are differentiated, if at all, for purposes of these various benefits.

Patriot Construction, Inc. hereby confirms that it affords its H-1B employees benefits on the same basis, and in accordance with the same criteria, as offered to U.S. workers.

Patriot Construction, Inc.

PATRIOT CONSTRUCTION

2022 - 2023 Benefits Guide

See inside to learn more about your benefits

September 1, 2022 - August 31, 2023

Patriot Construction, Inc.

Welcome

Your benefits are an important part of your overall compensation. We are pleased to offer a comprehensive array of quality benefits to protect your health, your family and your way of life. This brochure was designed to answer some of the basic questions you may have about your benefits. Please read it carefully along with any supplemental materials you receive.

Eligibility

You are eligible for benefits if you work 30 or more hours per week. You may also enroll your eligible family members under certain plans you choose for yourself. Eligible family members include:

- Your legally married spouse
- Your Registered Domestic Partner (RDP) and their children, where applicable by state law
- Your children who are your natural children, stepchildren, adopted children, or children for whom you have legal custody (age restrictions may apply). Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

When Coverage Begins

You become eligible for coverage first of the month following 60 days. If you do not enroll for coverage within 60 days of your hire date, you will not receive health coverage during the plan year unless you experience a qualified family status change (see- Making changes during the year for details).

Required Information

When you enroll, you will be required to enter a Social Security number (SSN) for all covered dependents. The Affordable Care Act (ACA), otherwise known as health care reform, requires the company to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.

Choose Carefully!

Due to IRS regulations, you cannot change your elections until the next annual Open Enrollment period, unless you have a Qualifying Event during the year. Following are examples of the most common Qualifying Events:

- Marriage or divorce
- Birth or adoption of a child
- Child reaching age 26
- Death of a spouse, Registered Domestic Partner (RDP), or child
- Change in child custody
- Change in coverage election made by your spouse/RDP during his/her employer's Open Enrollment period
- You lose coverage under your spouse's/RDP's plan

To make changes to your benefit elections, you must contact human resources within 31 days of the Qualifying Event (including newborns). Be prepared to show documentation of the event such as a marriage license, birth certificate, or a divorce decree. If changes are not submitted on time, you must wait until the next Open Enrollment period to make your election changes.

Qualifying Life Event - QLE

Key Terms in Cost Sharing

Deductible
The amount you pay out of your pocket for certain covered services each year before your plan starts to pay.

Out-of-Pocket Maximum
The most you have to pay out-of-pocket each year for health care services. Check your plan details to see if your deductible is part of your Out-of-Pocket maximum.

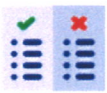
Benefit Accumulation
Deductibles and out-of-pocket maximums run calendar year, 1/1 - 12/31 regardless of plan renewal date, member effective date or open enrollment. On 1/1 each year, deductibles and out-of-pocket maximums will reset to $0 and start accruing again for the new calendar year.

Copay
A fixed amount you typically pay for a covered services like doctor visits.

Coinsurance
Your share of health plan costs (a percentage of total cost) after meeting your deductible.

Formulary
A medical plan's formulary is a preferred brand-name drug list of the most cost-effective outcome-based drugs. You pay less when using a drug on the plan's formulary list.

In and Out-of-Network Providers
Benefit plans develop networks by contracting with doctors, hospitals, labs, etc., who have agreed to provide health care services to members at negotiated rates. You generally pay less out of pocket when you use in-network providers.



Explanation of Benefits (EOB)
After you receive medical services, your insurance will provide you with an EOB. It will outline details regarding how your insurance processed your medical claim, including what portion of the charges your insurance paid and what portion, if any, you are responsible for paying.

Benefits Terminology

Scan the QR codes included in this guide to learn more about your benefits.

Visit your phone's app store to download a QR code reader/scanner app.

Know Your Care Options

Go to the Doctor's Office for:

- Annual exams and general health issues
- Cold and flu symptoms
- Minor aches and pains
- Vaccinations

Access Telehealth for:

- Allergies
- Anxiety issues
- Back problems
- Bronchitis
- Cold and flu symptoms
- Diarrhea and constipation
- Ear infections
- Headaches and migraines
- Rash and skin problems
- Sprains and strains
- Urinary tract infections

Go to an Urgent Care Center for:

- Diagnostic X-rays and laboratory tests
- Minor broken bones (e.g., fingers, toes)
- Minor infections and rashes
- Sprains, strains and cuts
- Stomach pain

Go to the Emergency Room for:

- Chest pain, shortness of breath and other symptoms of heart attack or stroke
- Heavy bleeding
- Major broken bones (e.g., arms, legs)
- Major lacerations and burns

Medical

Following is a high-level overview of the coverage available. For complete coverage details, please refer to the Summary Plan Description.

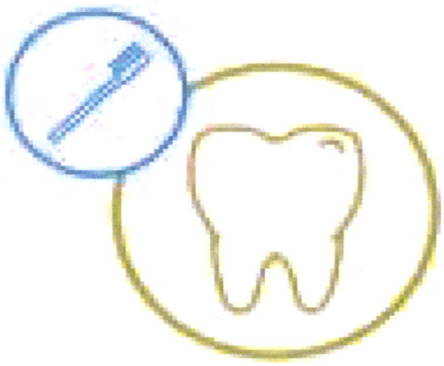
CaliforniaChoice® Your Health. Your Choice.®		Kaiser **Gold HMO B**		Kaiser **Silver HMO A**		Kaiser **Silver HMO B**		Sutter Health Plus **Gold HMO B**
Provider Network		Network		Network		Network		Network
Deductible (per calendar year)								
Individual	HMO:	$250	HMO:	$2,100	HMO:	$1,650	HMO:	$250
Family	HMO:	$500	HMO:	$4,200	HMO:	$3,300	HMO:	$500
Out-of-Pocket Maximum (per calendar year)								
Individual	HMO:	$7,800 (incl ded)	HMO:	$8,200 (incl ded)	HMO:	$8,200 (incl ded)	HMO:	$7,800 (incl ded)
Family	HMO:	$15,600 (incl ded)	HMO:	$16,400 (incl ded)	HMO:	$16,400 (incl ded)	HMO:	$15,600 (incl ded)
Physician Services								
OV/Specialist	HMO:	$35/$55 ded waived	HMO:	$55/$80 ded waived	HMO:	$55/$80 ded waived	HMO:	$35/$55 ded waived
Preventive Care	HMO:	No Charge	HMO:	No Charge	HMO:	No Charge	HMO:	No Charge
Diagnostic Lab/X-Ray	HMO:	$35/$55 ded waived	HMO:	$30/$75 ded waived	HMO:	$30/$75 ded waived	HMO:	$35/$55 ded waived
Prescription Drugs								
Deductible	HMO:	$250	HMO:	$500	HMO:	$350	HMO:	$250
Tier 1 (Generic Formulary)	HMO:	$15 ded waived	HMO:	$20 ded waived	HMO:	$20 ded waived	HMO:	$15 ded waived
Tier 2 (Preferred Brand Formulary)	HMO:	$40 ded waived	HMO:	$75 ded waived	HMO:	$75 after $350	HMO:	$40 ded waived
Tier 3 (Non-Preferred Brand Formulary)	HMO:	$40 ded waived	HMO:	$75 ded waived	HMO:	$75 after $350	HMO:	$70 ded waived
Tier 4 (Specialty Drugs)	HMO:	20% ded waived; $250 max/script	HMO:	20% after $500; $250 max/script	HMO:	20% after 4350; $250 max/script	HMO:	20% ded waived; $250 max/scipt
Hospital Facility Services								
Inpatient Hospital Services	HMO:	$600/day after ded; 5 days/admit	HMO:	45% after ded	HMO:	40% after ded	HMO:	$600/day after ded; 5 days/admit
Outpatient Surgery in a Hospital	HMO:	$335 after ded	HMO:	45% after ded	HMO:	40% after ded	HMO:	$300 after ded
Emergency Services								
Emergency Room	HMO:	$250 (waived if admitted) after ded	HMO:	45% after ded	HMO:	40% after ded	HMO:	$250 after ded (waived if admitted)
Urgent Care	HMO:	$35 ded waived	HMO:	$55 ded waived	HMO:	$55 ded waived	HMO:	$35 ded waived
Compliance								
Medicare Part D Creditable		Creditable		Creditable		Creditable		Creditable

Dental

DIRECT DENTAL ADMINISTRATORS, LLC	Low Dental Plan- Direct Dental/Cypress		
	CEN Network	In-Network	Out-of-Network
Deductible (per calendar year)			
Individual	$25	$50	$50
Family	$75	$150	$150
Waived Preventive Services	Yes	Yes	Yes
Benefit Maximum (per calendar year; Preventive, Basic, and Major Services combined)			
Per Individual	$1,000	$1,000	$1,000
Covered Services			
Preventive Services	100%	100%	100%
Basic Services	80%	80%	80%
Major Services	60%	50%	50%
Orthodontia **(Adults & Children)**	Yes	Yes	Yes
Lifetime Maximum	$1,750	$1,750	$1,750

The Cypress dental plan gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and reduce your out-of-pocket costs if you choose a provider who participates in the network. Following is a high-level overview of the coverage available.

DIRECT DENTAL ADMINISTRATORS, LLC	High Dental Plan- Direct Dental/Cypress		
	CEN Network	In-Network	Out-of-Network[1]
Deductible (per calendar year)			
Individual	$25	$50	$50
Family	$75	$4,150	$150
Waived Preventive Services	Yes	Yes	Yes
Benefit Maximum (per calendar year; Preventive, Basic, and Major Services combined)			
Per Individual	$1,500	$1,500	$1,500
Covered Services			
Preventive Services	100%	100%	100%
Basic Services	90%	80%	80%
Major Services	60%	50%	50%
Orthodontia (Adults & Children)	Yes	Yes	Yes
Lifetime Maximum	$1,750	$1,750	$1,750

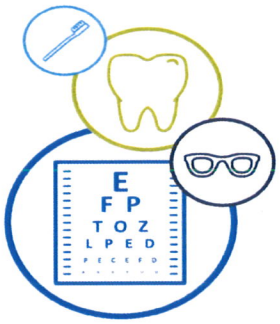


Vision

The Cal Choice vision plan gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and reduce your out-of-pocket costs if you choose a provider who participates in the network.

Out of Network You pay(after copay if applicable)

CaliforniaChoice® Your Health. Your Choice.®	EyeMed	VSP
Exam	$10 Copay	$10 Copay
Lenses		
Single Vision	$10 Copay	$10 Copay
Lined Bifocal	$10 Copay	$10 Copay
Lined Trifocal	$10 Copay	$10 Copay
Frames	Up to $100 retail value	Up to $180 retail value
Contact Lenses in Lieu of Frames	$10 Copay	$10 Copay
Frequency (From Date of Service)		
Exam	Every 12 Months	
Lenses	Every 12 Months	
Frames	Every 12 Months	



Life & AD&D

CaliforniaChoice® Your Health. Your Choice.®

Patriot Construction, Inc. sponsors **$10,000** of Group Life/AD&D for each employee.

CaliforniaChoice®
Your Health. Your Choice.®

Chiropractic Coverage-Landmark Health

Landmark	Benefits and Co-payments
Office Visit	$15 co-payment
Maximum Annual Visits	20 visits
X-ray Services	$75 annual maximum benefit
Discount for non-covered services	25%
Durable Medical Equipment Purchase of Rental**	$50 annual maximum benefit
**X-ray services must be prescribed by a Partcipating Chiropractor	
**Durable Medical Equipment must be prescribed by a Partcipating Chiropractor	
**Please refer to Landmark Schedule of Benefits for a detailed description of covered services	

Patriot Construction, Inc.

Dependent Contribution - Weekly

Actual Age	Kaiser Gold HMO B	Kaiser Silver HMO A	Kaiser Silver HMO B	Sutter Health Plus Gold HMO B
0-14	66.38	55.64	56.62	69.16
15	72.00	60.30	61.37	75.30
16	74.14	62.08	63.18	77.65
17	76.29	63.86	65.00	80.01
18	78.60	65.78	66.95	82.53
19	77.69	64.47	65.68	85.07
20	80.08	66.45	67.70	87.69
21	82.56	68.51	69.80	90.40
22	82.56	68.51	69.80	90.40
23	82.56	68.51	69.80	90.40
24	82.56	68.51	69.80	90.40
25	82.89	68.78	70.08	90.76
26	84.54	70.15	71.47	92.57
27	86.52	71.80	73.15	94.74
28	89.74	74.47	75.87	98.27
29	92.38	76.66	78.10	101.16
30	93.70	77.76	79.22	102.60
31	95.68	79.40	80.89	104.77
32	97.66	81.05	82.57	106.94
33	98.90	82.08	83.62	108.30
34	100.22	83.17	84.73	109.75
35	100.88	83.72	85.29	110.47
36	101.54	84.27	85.85	111.19
37	102.21	84.81	86.41	111.92
38	102.87	85.36	86.97	112.64
39	104.19	86.46	88.08	114.09
40	105.51	87.56	89.20	115.53
41	107.49	89.20	90.87	117.70
42	109.39	90.78	92.48	119.78
43	112.03	92.97	94.71	122.67
44	115.33	95.71	97.51	126.29
45	119.21	98.93	100.79	130.54
46	123.84	102.76	104.70	135.60
47	129.03	107.08	109.09	141.30
48	134.98	112.01	114.12	147.81
49	140.84	116.88	119.07	154.22
50	147.45	122.36	124.66	161.46
51	153.97	127.77	130.17	168.60
52	161.15	133.73	136.24	176.46
53	168.42	139.76	142.38	184.42
54	176.26	146.27	149.02	193.01
55	184.10	152.78	155.65	201.59
56	192.60	159.83	162.84	210.90
57	201.19	166.96	170.10	220.31
58	210.35	174.56	177.84	230.34
59	214.89	178.33	181.68	235.31
60	224.06	185.94	189.43	245.35
61	231.98	192.51	196.13	254.03
62	237.18	196.83	200.53	259.72
63	243.71	202.24	206.04	266.86
64+	247.67	205.53	209.39	271.20

Patriot Construction

Contribution- Weekly

DIRECT DENTAL ADMINISTRATORS, LLC

Patriot Construction will continue to contribute 100% for Employee Only for the Kaiser Gold B plan

please see personalized worksheet.

The cost of your elected benefits are automatically deducted from your paycheck. The total payroll deduction amount will depend on the plan you select and if you are covering an eligible spouse and or dependent(s). Your deduction is based upon the demographics of your eligible dependent(s).

Voluntary Dental

Coverage Tier	High Plan	Low Plan
Employee Only	$0.00	$0.00
Employee + Spouse	$13.77	$12.57
Employee + Child(ren)	$16.12	$14.60
Employee + Family	$29.90	$27.16

Voluntary Vision

Coverage Tier	EyeMed	VSP
Employee Only	$2.25	$2.98
Employee + Family	$4.79	$7.22

Contact Information

Coverage	Carrier	Phone #	Website
Medical/Vision/Chiro	Cal Choice	(800) 558-8003	www.calchoice.com
Group Life & AD&D	Cal Choice	(800) 558-8003	www.calchoice.com
Dental	Direct Dental	(855) 844-0626	info@directdentalplans.com

Questions?

If you have additional questions, you may also contact:

Maricruz Castellanos
(209) 982-9900
mari@patriotbuilds.com

Elizabeth Bautista
(209) 550-3747
elizabeth.bautista@hubinternational.com

Josie Chapa (Bi-lingual)
(209) 550-3713
jocelyn.chapa@hubinternational.com

Cost of Benefits

Your contributions toward the cost of benefits are automatically deducted from your paycheck before taxes. The amount will depend upon the plan you select and if you choose to cover eligible family members.

Important Note: The material in this benefits brochure is for informational purposes only and is neither an offer of coverage or medical or legal advice. It contains only a partial description of plan or program benefits and does not constitute a contract. Please refer to the Summary Plan Description (SPD) for complete plan details. In case of a conflict between your plan documents and this information, the plan documents will always govern. **Annual Notices:** ERISA and various other state and federal laws require that employers provide disclosure and annual notices to their plan participants. The Company will distribute all required notices annually.

HUB | capax
Giddings, Corby, Hymes

Important Notices

Women's Health and Cancer Rights Act

On January 1, 1999, a federal law, the Women's Health and Cancer Rights Act of 1998, became effective, which affects our company plan options. This law requires group health plans that provide coverage for mastectomies (ours does) and to also provide coverage for reconstructive surgery and prostheses following mastectomies. As required under the law, we have included this notice to inform you about it. The law mandates that a participant or eligible beneficiary who is receiving benefits, on or after the law's effective date (January 1, 1999, for our Plan), for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

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

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual deductible, coinsurance and/or copayment provisions otherwise applicable under the Plan.

Notice Regarding Wellness Program

The on-line carrier Screening Program is a voluntary wellness program available to all enrollees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information non-discrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. You are not required to participate in the health screening.

The information from your wellness screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the Wellness Screening Program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

Mental Health Parity Act

Per the Mental Health Parity Act, benefits for mental health and substance-use disorder must be treated like benefits for regular medical and surgical care. For example, if there is no limitation on the number of days for inpatient and number of visits for outpatient medical care, then there can be no limitation for mental health and substance-use disorder treatments. As always, treatments must be medically necessary to qualify for coverage. Plan participants should review their plan's certificate of coverage or benefit document for specific information about coverage, limitations and exclusions for mental health care and substance-use disorder treatments.

Summaries of Benefits and Coverage (SBCs)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. To help you make an informed choice, the company makes available a Summaries of Benefits and Coverage (SBCs), which summarize important information about our health coverage in a standard format, to help you compare across options. The SBCs also include a Glossary of Health Coverage and Medical Terms to help you better understand health care terms used in the SBCs.

Employee Benefits Notices and Forms

Annual, New Hire, and Other Notices and Forms

Please note: While HUB is providing these notices as a courtesy to its clients, HUB does not provide legal or tax advice. HUB makes no representation or warranty as to the accuracy or completeness of these documents and is not obligated to update them. Consult your attorney and/or professional advisor as to your organization's specific circumstances and legal, tax or other requirements.

HUB | CAPAX

Giddings, Corby, Hynes

Section I: Annual Notices and Forms for All Plans

Medicare Part D Creditable Coverage Notice

Important Notice from Patriot Construction 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 Patriot Construction (the "Plan Sponsor") 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) The Plan Sponsor has determined that the prescription drug coverage offered by the California Choice 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 15th to December 7th.

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

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

If you decide to join a Medicare drug plan, your current Plan Sponsor coverage may be affected. Moreover, if you do decide to join a Medicare drug plan and drop your current Plan Sponsor coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact the person listed at the end of this notice for more information about what happens to your coverage if you enroll in a Medicare Part D prescription Drug 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 the Plan Sponsor 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 the Plan Sponsor changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You"

handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date:	9/1/2022
Name of Entity/Sender:	Patriot Construction
Contact Position/Office:	HR Manager
Address:	4646 Qantas Lance B4-B5 Stockton, CA 95206
Phone Number:	209-451-9207

Medicare Part D Non-Creditable Coverage Notice

Important Notice from Patriot Construction 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 Patriot Construction (the "Plan Sponsor") 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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) The Plan Sponsor has determined that the prescription drug coverage offered by the California Choice (the "Plan") is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non- Creditable Coverage. This is important because, most likely, you will get

more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

(3) You can keep your current coverage from the Plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?

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

However, if you decide to drop your current coverage with the Plan Sponsor, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the Plan.

Since you are losing creditable prescription drug coverage under the Plan, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

Since the coverage under the Plan, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 current Plan Sponsor coverage may be affected. Moreover, if you do decide to join a Medicare drug plan and drop your current Plan Sponsor coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact the person listed at the end of this notice for more information about what happens to your coverage if you enroll in a Medicare Part D prescription Drug Plan.

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 the Plan Sponsor changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

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

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

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

Date:	9/1/2022
Name of Entity/Sender:	Patriot Construction
Contact Position/Office:	HR Manager

CHIPRA/CHIP Notice

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021 Contact your State for more information on eligibility -

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

Employee Benefits Security Administration

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

Centers for Medicare & Medicaid Services

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

Annual Notice of Women's Health and Cancer Rights Act

Do you know that your plan, as required by the Women's Health and Cancer Right Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and treatment for complications resulting from a mastectomy, including lymphedema? Call your plan administrator at **209-451-9207** for more information.

Notice of Availability of HIPAA Notice of Privacy Practices – *Only applies to employers who have access to PHI.*

Patriot Construction
4646 Qantas Lance B4-B5 Stockton, CA 95206
9/1/2022

To: Participants in the If Yes, list all plan names here

From: HR Manager

Re: Availability of Notice of Privacy Practices

The If Yes, list all plan names here (each a "Plan") maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Tina Vang , HR Manager at 4646 Qantas Lance B4-B5 Stockton, CA 95206 , 209-451-9207, tina@patriotbuilds.com.

Patient Protection Disclosures – *Only applies to plans that require the designation of a primary care provider.*

California Choice generally requires 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. Until you make this designation, California Choice designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Maricruz , HR Manager at 4646 Qantas Lance B4-B5 Stockton, CA 95206 , 209-451-9207,

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from California Choice 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 the HR Manager at 4646 Qantas Lance B4-B5 Stockton, CA 95206 , 209-451-9207, .

Health Insurance Waiver Form (Optional) – *For plans that don't enroll electronically and/or want proof of employees declining coverage*

Note: The employer may need to revise this document according to its Plan terms and administration.

Employee Name:		**Manager:**
Date:	**Department:**	**Position:**

Employee Initials:

_____ I acknowledge that I (and any eligible dependents) have been offered coverage with the opportunity to enroll or decline in the **California Choice** .

_____ I decline enrolling myself or eligible dependents in the group health plan coverage because:

Employee (check one):

- ☐ I decline medical coverage and do not have insurance
- ☐ I decline medical coverage because I have other insurance coverage provided by (check one):
  - ☐ Insurance Company Name:_____
    Policy/Group Number: _____
  - ☐ Through (Employer Name):_____

Employee's Dependents (check if applicable):

- ☐ I decline medical coverage for my eligible dependents. Below is a list of each dependent and the reason for the declinations.
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Notice of Possible Enrollment Rights

If you or a member of your family loses coverage or has a change in family or employment circumstances, you or they may be eligible to enroll before the next open enrollment. Contact **Tina Vang** , **HR Manager** at **4646 Qantas Lance B4-B5 Stockton, CA 95206** , **209-451-9207**, **tina@patriotbuilds.com** for more information if you think this may apply to you.

Printed Name: [redacted]

Date: [redacted]

Signature: [redacted]

Notice of Marketplace Coverage Options – *Must be provided within 14 days of day of hire.*

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2021 for coverage starting January 1, 2022.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% (as adjusted annually) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact. **Tina Vang , HR Manager** at **4646 Qantas Lance B4-B5 Stockton, CA 95206** , **209-451-9207**, **tina@patriotbuilds.com**.

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

[1] An employer-sponsored 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.

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 Patriot Construction	4. Employer Identification Number (EIN) 26-0539294
5. Employer address, 7. City, 8. State, 9. Zip Code 4646 Qantas Lance B4-B5 Stockton, CA 95206	6. Employer phone number 209-451-9207
10. Who can we contact about employee health coverage at this job? HR Manager	
11. Phone number (if different from above) 209-451-9207	12. Email address maricruz@patriotbuilds.com

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 working 30 or more hours a week and have met the waiting period.
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are: Spouses, Domestic Partners, and children of the same.
  - ☐ 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.

Notice of Special Enrollment Rights – *Must be provided at or prior to initial enrollment.*

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, 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 no later than **Type Answer Here** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, 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 dependents. However, you must request enrollment no later than **Type Answer Here** after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009, if either of the following two events occur, you will have **Type Answer Here** after the date of the event to request enrollment in your employer's plan:

- Your dependents lose Medicaid or CHIP coverage because they are no longer eligible.
- Your dependents become eligible for a state's premium assistance program.

To take advantage of special enrollment rights, you must experience a qualifying event *and* provide the employer plan with timely notice of the event and your enrollment request. **If Yes, describe process here**.

To request special enrollment or obtain more information, contact **Patriot Construction** , Human Resource Dept. at **209-451-9207**.

General COBRA Notice – *Must be provided 90 days after coverage begins*

General Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage **must pay** for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Patriot Construction , and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within If Yes, Type Answer Here after the qualifying event occurs. You must provide this notice to: Tina Vang . If Yes, Add description here

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If Yes, Add description here

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be

available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **https://www.medicare.gov/medicare-and-you**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

---

[1] **https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods**.

Online Wage Library - FLC Wage Search Results

Thursday, May 11, 2023 New Quick Search New Search Wizard

You selected the All Industries database for 7/2022 - 6/2023. Your search returned the following:

Area Code:	44700
Area Title:	Stockton-Lodi, CA
GeoLevel:	1
OES/SOC Code:	13-2011
OES/SOC Title:	Accountants and Auditors
Level 1 Wage:	$25.88 hour - $53,830 year
Level 2 Wage:	$31.93 hour - $66,414 year
Level 3 Wage:	$37.99 hour - $79,019 year
Level 4 Wage:	$44.04 hour - $91,603 year
Mean Wage (H-2B):	$38.05 hour - $79,144 year

This wage applies to the following O*NET occupations:
13-2011.00 Accountants and Auditors

> Examine, analyze, and interpret accounting records to prepare financial statements, give advice, or audit and evaluate statements prepared by others. Install or advise on systems of recording costs or other financial and budgetary data.
> O*NET JobZone: 4 -- Education & Training Code: 4-Bachelor's degree

The offered wage must be at, or above the federal or state or local minimum wage, whichever is higher. The federal minimum wage is $7.25/hr effective July 24, 2009.

OMB Approval: 1205-0310
Expiration Date: 12/31/2024

Labor Condition Application for Nonimmigrant Workers
Form ETA-9035 & 9035E
U.S. Department of Labor

Please read and review the filing instructions carefully before completing the Form ETA- 9035 or 9035E. A copy of the instructions can be found at https://www.dol.gov/agencies/eta/foreign-labor/. In accordance with Federal Regulations at 20 CFR 655.730(b), incomplete or obviously inaccurate Labor Condition Applications (LCAs) will not be certified by the Department of Labor (DOL). For all submissions, both electronic (Form ETA- 9035E) or paper (Form ETA- Form 9035 where the employer has notified DOL that it will submit this form non-electronically due to a disability or received permission from DOL to file non-electronically due to lack of Internet access), ALL required fields/items containing an asterisk (*) must be completed as well as any fields/ items where a response is conditional as indicated by the section (§) symbol.

A. Employment-Based Nonimmigrant Visa Information

1. Indicate the type of visa classification supported by this application *(Write classification symbol)*: *	H-1B

B. Temporary Need Information

1. Job Title * Job Cost Accountant		
2. SOC (ONET/OES) code * 13-2011	3. SOC (ONET/OES) occupation title * Accountants and Auditors	
4. Is this a full-time position? * ☑ Yes ☐ No	**Period of Intended Employment**	
	5. Begin Date * *(mm/dd/yyyy)* 10/1/2023	6. End Date * *(mm/dd/yyyy)* 9/30/2026

7. Worker positions needed/basis for the visa classification supported by this application

1 **Total Worker Positions Being Requested for Certification ***

Basis for the visa classification supported by this application
(indicate total workers in each applicable category)

1	a. New employment *	0	d. New concurrent employment *
0	b. Continuation of previously approved employment without change with the same employer*	0	e. Change in employer *
0	c. Change in previously approved employment *	0	f. Amended petition *

C. Employer Information

1. Legal business name * Patriot Construction Inc.		
2. Trade name/Doing Business As (DBA), if applicable		
3. Address 1 * 4646 Qantas Lane		
4. Address 2 Ste. B-4		
5. City * Stockton	6. State * California	7. Postal code * 95206
8. Country * United States Of America	9. Province	
10. Telephone number * +1 (209) 456-6154	11. Extension	
12. Federal Employer Identification Number (FEIN from IRS) * 26-0539294	13. NAICS code (must be at least 4-digits) * 236220	

Labor Condition Application for Nonimmigrant Workers
Form ETA-9035 & 9035E
U.S. Department of Labor

D. Employer Point of Contact Information

Important Note: The information contained in this Section must be that of an employee of the employer who is authorized to act on behalf of the employer in labor certification matters. The information in this Section must be different from the agent or attorney information listed in Section E, unless the attorney is an employee of the employer.

1. Contact's last (family) name *	2. First (given) name *	3. Middle name(s)
Maldonado	Susana	
4. Contact's job title *		
Accounting Manager		
5. Address 1 *		
4646 Qantas Lane		
6. Address 2		
Ste. B-4		
7. City *	8. State *	9. Postal code *
Stockton	California	95206
10. Country *	11. Province	
United States Of America		
12. Telephone number *	13. Extension	14. E-Mail address
+1 (209) 323-2727		susana@patriotbuilds.com

E. Attorney or Agent Information (If applicable)

Important Note: The employer authorizes the attorney or agent identified in this section to act on its behalf in connection with the filing of this application.

1. Is the employer represented by an attorney or agent in the filing of this application? * If "Yes," complete the remainder of Section E below.	☑ Yes	☐ No

2. Attorney or Agent's last (family) name §	3. First (given) name §	4. Middle name(s)
Binsacca	David	
5. Address 1 §		
456 Montgomery Street		
6. Address 2		
Flr. 19		
7. City §	8. State §	9. Postal code §
San Francisco	California	94104
10. Country §	11. Province	
United States Of America		
12. Telephone number §	13. Extension	14. E-Mail address
+1 (415) 434-1161		david@jspvisa.com
15. Law firm/Business name §		16. Law firm/Business FEIN §
JEWELL STEWART & PRATT PC		26-3889921
17. State Bar number (only if attorney) §		18. State of highest court where attorney is in good standing (only if attorney) §
10834		Idaho
19. Name of the highest State court where attorney is in good standing (only if attorney) §		
Supreme Court		

Labor Condition Application for Nonimmigrant Workers
Form ETA-9035 & 9035E
U.S. Department of Labor

F. Employment and Wage Information

Important Note: The employer must define the intended place(s) of employment with as much geographic specificity as possible. Each intended place(s) of employment listed below must be the worksite or physical location where the work will actually be performed and cannot be a P.O. Box. The employer must identify all intended places of employment, including those of short duration, on the LCA. 20 CFR 655.730(c)(5). If the employer is submitting this form non-electronically and the work is expected to be performed in more than one location, an attachment must be submitted in order to complete this section. An employer has the option to use either a single Form ETA-9035/9035E or multiple forms to disclose all intended places of employment. If the employer has more than ten (10) intended places of employment at the time of filing this application, the employer must file as many additional LCAs as are necessary to list all intended places of employment. See the form instructions for further information about identifying all intended places of employment.

a. ***Place of Employment Information*** 1

1. Enter the estimated number of workers that will perform work at this place of employment under the LCA.*	1
2. Indicate whether the worker(s) subject to this LCA will be placed with a secondary entity at this place of employment. *	❑ Yes ☑ No
3. If "Yes" to question 2, provide the legal business name of the secondary entity. §	
4. Address 1 * 4646 Qantas Lane	
5. Address 2 Ste. B-4	
6. City * Stockton	7. County * San Joaquin
8. State/District/Territory * California	9. Postal code * 95206
10. Wage Rate Paid to Nonimmigrant Workers * From* $ 53830 . 00 To: $ _____ . ____	10a. Per: (Choose only one)* ☐ Hour ☐ Week ☐ Bi-Weekly ☐ Month ☑ Year
11. Prevailing Wage Rate * $ 53830 . 00	11a. Per: (Choose only one)* ☐ Hour ☐ Week ☐ Bi-Weekly ☐ Month ☑ Year

Questions 12-14. Identify the source used for the prevailing wage (PW) *(check and fully complete only one)*: *

12. ☐	**A Prevailing Wage Determination (PWD) issued by the Department of Labor**	a. PWD tracking number §
13. ☑	**A PW obtained independently from the Occupational Employment Statistics (OES) Program**	
	a. Wage Level *(check one):* § ☑ I ☐ II ☐ III ☐ IV ☐ N/A	b. Source Year § 7/1/2022 - 6/30/2023
14. ☐	**A PW obtained using another legitimate source (other than OES) or an independent authoritative source**	
	a. Source Type *(check one):* § ☐ CBA ☐ DBA ☐ SCA ☐ Other/ PW Survey	b. Source Year §
	c. If responded "Other/ PW Survey" in question 14.a, enter the name of the survey producer or publisher §	
	d. If responded "Other/ PW Survey" in question 14.a, enter the title or name of the PW survey §	

Labor Condition Application for Nonimmigrant Workers
Form ETA-9035 & 9035E
U.S. Department of Labor

G. Employer Labor Condition Statements

Important Note: In order for your application to be processed, you MUST read Section G of the Form ETA-9035CP - General Instructions for the 9035 & 9035E under the heading "Employer Labor Condition Statements" and agree to all four (4) labor condition statements summarized below:

(1) **Wages:** The employer shall pay nonimmigrant workers at least the prevailing wage or the employer's actual wage, whichever is higher, and pay for non-productive time. The employer shall offer nonimmigrant workers benefits and eligibility for benefits provided as compensation for services on the same basis as the employer offers to U.S. workers. The employer shall not make deductions to recoup a business expense(s) of the employer including attorney fees and other costs connected to the performance of H-1B, H-1B1, or E-3 program functions which are required to be performed by the employer. This includes expenses related to the preparation and filing of this LCA and related visa petition information. 20 CFR 655.731;

(2) **Working Conditions:** The employer shall provide working conditions for nonimmigrants which will not adversely affect the working conditions of workers similarly employed. The employer's obligation regarding working conditions shall extend for the duration of the validity period of the certified LCA or the period during which the worker(s) working pursuant to this LCA is employed by the employer, whichever is longer. 20 CFR 655.732;

(3) **Strike, Lockout, or Work Stoppage:** At the time of filing this LCA, the employer is not involved in a strike, lockout, or work stoppage in the course of a labor dispute in the occupational classification in the area(s) of intended employment. The employer will notify the Department of Labor within 3 days of the occurrence of a strike or lockout in the occupation, and in that event the LCA will not be used to support a petition filing with the U.S. Citizenship and Immigration Services (USCIS) until the DOL Employment and Training Administration (ETA) determines that the strike or lockout has ended. 20 CFR 655.733; and

(4) **Notice:** Notice of the LCA filing was provided no more than 30 days before the filing of this LCA or will be provided on the day this LCA is filed to the bargaining representative in the occupation and area of intended employment, or if there is no bargaining representative, to workers in the occupation at the place(s) of employment either by electronic or physical posting. This notice was or will be posted for a total period of 10 days, except that if employees are provided individual direct notice by e-mail, notification need only be given once. A copy of the notice documentation will be maintained in the employer's public access file. A copy of this LCA will be provided to each nonimmigrant worker employed pursuant to the LCA. The employer shall, no later than the date the worker(s) report to work at the place(s) of employment, provide a signed copy of the certified LCA to the worker(s) working pursuant to this LCA. 20 CFR 655.734.

1. **I have read and agree to** Labor Condition Statements 1, 2, 3, and 4 above and as fully explained in Section G of the Form ETA-9035CP – General Instructions for the 9035 & 9035E and the Department's regulations at 20 CFR 655 Subpart H. *	☑ Yes ☐ No

H. Additional Employer Labor Condition Statements –H-1B Employers ONLY

Important Note: In order for your H-1B application to be processed, you MUST read Section H – Subsection 1 of the Form ETA 9035CP – General Instructions for the 9035 & 9035E under the heading "Additional Employer Labor Condition Statements" and answer the questions below.

a. Subsection 1

1. At the time of filing this LCA, is the employer H-1B dependent? §	☐ Yes ☑ No
2. At the time of filing this LCA, is the employer a willful violator? §	☐ Yes ☑ No
3. If "Yes" is marked in questions H.1 and/or H.2, you must answer "Yes" or "No" regarding whether the employer will use this application ONLY to support H-1B petitions or extensions of status for exempt H-1B nonimmigrant workers? §	☐ Yes ☐ No
4. If "Yes" is marked in question H.3, identify the statutory basis for the exemption of the H-1B nonimmigrant workers associated with this LCA. §	☐ $60,000 or higher annual wage ☐ Master's Degree or higher in related specialty ☐ Both
H-1B Dependent or Willful Violator Employers -Master's Degree or Higher Exemptions ONLY	
5. Indicate whether a completed Appendix A is attached to this LCA covering any H-1B nonimmigrant worker for whom the statutory exemption will be based **ONLY** on attainment of a Master's Degree or higher in related specialty. §	☐ Yes ☐ No ☐ N/A

Labor Condition Application for Nonimmigrant Workers
Form ETA-9035 & 9035E
U.S. Department of Labor

If you marked "Yes" to questions H.a.1 (H-1B dependent) and/or H.a.2 (H-1B willful violator) and "No" to question H.a.3 (exempt H-1B nonimmigrant workers), you MUST read Section H – Subsection 2 of the Form ETA 9035CP – General Instructions for the 9035 & 9035E under the heading "Additional Employer Labor Condition Statements" and indicate your agreement to all three (3) additional statements summarized below.

b. Subsection 2

A. **Displacement:** An H-1B dependent or willful violator employer is prohibited from displacing a U.S. worker in its own workforce within the period beginning 90 days before and ending 90 days after the date of filing of the visa petition. 20 CFR 655.738(c);

B. **Secondary Displacement:** An H-1B dependent or willful violator employer is prohibited from placing an H-1B nonimmigrant worker(s) with another/secondary employer where there are indicia of an employment relationship between the nonimmigrant worker(s) and that other/secondary employer (thus possibly affecting the jobs of U.S. workers employed by that other employer), unless and until the employer subject to this LCA makes the inquiries and/or receives the information set forth in 20 CFR 655.738(d)(5) concerning that other/secondary employer's displacement of similarly employed U.S. workers in its workforce within the period beginning 90 days before and ending 90 days after the date of such placement. 20 CFR 655.738(d). Even if the required inquiry of the secondary employer is made, the H-1B dependent or willful violator employer will be subject to a finding of a violation of the secondary displacement prohibition if the secondary employer, in fact, displaces any U.S. worker(s) during the applicable time period; and

C. **Recruitment and Hiring:** Prior to filing this LCA or any petition or request for extension of status for nonimmigrant worker(s) supported by this LCA, the H-1B dependent or willful violator employer must take good faith steps to recruit U.S. workers for the job(s) using procedures that meet industry-wide standards and offer compensation that is at least as great as the required wage to be paid to the nonimmigrant worker(s) pursuant to 20 CFR 655.731(a). The employer must offer the job(s) to any U.S. worker who applies and is equally or better qualified for the job than the nonimmigrant worker. 20 CFR 655.739.

6. **I have read and agree** to Additional Employer Labor Condition Statements A, B, and C above and as fully explained in Section H – Subsections 1 and 2 of the Form ETA 9035CP – General Instructions for the 9035 & 9035E and the Department's regulations at 20 CFR 655 Subpart H. §	❑ Yes ❑ No

I. Public Disclosure Information

! **Important Note**: You must select one or both of the options listed in this Section.

1. Public disclosure information in the United States will be kept at: *	☑ Employer's principal place of business ❑ Place of employment

J. Notice of Obligations

A. Upon receipt of the certified LCA, the employer must take the following actions:

- Print and sign a hard copy of the LCA if filing electronically (20 CFR 655.730(c)(3));
- Maintain the original signed and certified LCA in the employer's files (20 CFR 655.705(c)(2); 20 CFR 655.730(c)(3); and 20 CFR 655.760); and
- Make a copy of the LCA, as well as necessary supporting documentation required by the Department of Labor regulations, available for public examination in a public access file at the employer's principal place of business in the U.S. or at the place of employment within one working day after the date on which the LCA is filed with the Department of Labor (20 CFR 655.705(c)(2) and 20 CFR 655.760).

B. The employer must develop sufficient documentation to meet its burden of proof with respect to the validity of the statements made in its LCA and the accuracy of information provided, in the event that such statement or information is challenged (20 CFR 655.705(c)(5) and 20 CFR 655.700(d)(4)(iv)).

C. The employer must make this LCA, supporting documentation, and other records available to officials of the Department of Labor upon request during any investigation under the Immigration and Nationality Act (20 CFR 655.760 and 20 CFR Subpart I).

I declare under penalty of perjury that I have read and reviewed this application and that to the best of my knowledge, the information contained therein is true and accurate. I understand that to knowingly furnish materially false information in the preparation of this form and any supplement thereto or to aid, abet, or counsel another to do so is a federal offense punishable by fines, imprisonment, or both (18 U.S.C. 2, 1001,1546,1621).

1. Last (family) name of hiring or designated official *	2. First (given) name of hiring or designated official *	3. Middle initial §
Cotta	Christopher	M.
4. Hiring or designated official title *		
CEO		
5. Signature *	6. Date signed *	

Labor Condition Application for Nonimmigrant Workers
Form ETA-9035 & 9035E
U.S. Department of Labor

K. LCA Preparer

Important Note: Complete this section if the preparer of this LCA is a person other than the one identified in either Section D (employer point of contact) or E (attorney or agent) of this application.

1. Last (family) name §	2. First (given) name §	3. Middle initial
4. Firm/Business name §		
5. E-Mail address §		

L. U.S. Government Agency Use (ONLY)

By virtue of the signature below, the Department of Labor hereby acknowledges the following:

This certification is valid from _____ to _____.

Department of Labor, Office of Foreign Labor Certification	Certification Date (date signed)
I-200-23131-014648	In Process
Case number	Case Status

The Department of Labor is not the guarantor of the accuracy, truthfulness, or adequacy of a certified LCA.

M. Signature Notification and Complaints

The signatures and dates signed on this form will not be filled out when electronically submitting to the Department of Labor for processing, but **MUST** be complete when submitting non-electronically. If the application is submitted electronically, any resulting certification **MUST** be signed *immediately upon receipt* from DOL before it can be submitted to USCIS for final processing.
Complaints alleging misrepresentation of material facts in the LCA and/or failure to comply with the terms of the LCA may be filed using the WH-4 Form with any office of the Wage and Hour Division, U.S. Department of Labor. A listing of the Wage and Hour Division offices can be obtained at www.dol.gov/whd. Complaints alleging failure to offer employment to an equally or better qualified U.S. worker, or an employer's misrepresentation regarding such offer(s) of employment, may be filed with the U.S. Department of Justice, Civil Rights Division, Immigrant and Employee Rights Section, 950 Pennsylvania Avenue, NW, # IER, NYA 9000, Washington, DC, 20530, and additional information can be obtained at www.justice.gov. Please note that complaints should be filed with the Civil Rights Division, Immigrant and Employee Rights Section at the Department of Justice only if the violation is by an employer who is H-1B dependent or a willful violator as defined in 20 CFR 655.710(b) and 655.734(a)(1)(ii).

For public burden statement information, please see Form ETA-9035CP General Instructions.

OMB Control No.: 1205-0310
Expiration Date: 10/31/2021

Labor Condition Application for H-1B, H-1B1 and E-3 Nonimmigrant Workers
Form ETA-9035CP –General Instructions for the 9035 & 9035E
U.S. Department of Labor

IMPORTANT: Please read these instructions carefully before completing the Form ETA-9035 or 9035E – Labor Condition Application (LCA) for Nonimmigrant Workers. These instructions contain full explanations of the questions and attestations that make up the LCA, Form ETA-9035 and 9035E, with further information about the employer's obligations provided in 20 CFR 655 Subpart H. If the employer plans to file non-electronically, which is allowed only for certain reasons set out below, ALL required fields and items containing an asterisk (*) must be completed as well as any fields and items where a response is conditioned on the response to another required section/field or item as indicated by the section (§) symbol.

In accordance with 20 CFR 655.740, once an LCA has been received from an employer, a determination will be made by the Department of Labor's (Department) Employment and Training Administration (ETA) Certifying Officer whether to certify the LCA or return it to the employer not certified. Where all items on the Form ETA-9035 or 9035E are complete and do not contain obvious inaccuracies, the ETA Certifying Officer will certify the LCA within 7 working days of the date the LCA is received and date-stamped by the Department. If the LCA is not certified pursuant to 20 CFR 655.740(a)(2)(i) or (ii), the ETA Certifying Officer will return it to the employer, or the employer's authorized agent or representative, explaining the reason(s) for such return without certification. Except in the case of a disqualification issued by the Wage Hour Administrator, the employer may submit a corrected LCA to the Department for review, which shall be treated as a new LCA and processed on a "first come, first served" basis.

Anyone who knowingly and willingly furnishes false information in the preparation of the Form ETA-9035 or 9035E and any supplement thereto, or aids, abets, or counsels another to do so is committing a Federal offense under 18 U.S.C. 1001 or other provisions of law.

OMB Notice: These reporting instructions have been approved under the Paperwork Reduction Act of 1995. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. Obligations to reply are mandatory (Immigration and Nationality Act (INA), Section 212(n) and (t) and 214(c)). Public reporting burden for this collection of information, which is to assist with program management and to meet Congressional and statutory requirements is estimated to average 75 minutes per response, including the time to review instructions, search existing data sources, gather and maintain the data needed, and complete and review the collection of information.

Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employment and Training Administration, Office of Foreign Labor Certification, 200 Constitution Ave., NW, Box PPII 12-200, Washington, DC, 20210. (Paperwork Reduction Project OMB 1205-0310). **Do NOT send the completed application to this address.**

HOW TO FILE

A. Who May File:
A United States (U.S.) employer who desires to apply for an LCA on behalf of a nonimmigrant worker(s) must file the Form ETA-9035 (paper) or Form ETA-9035E (electronic).

B. How to File and Retention of Records
1. Online filing of the Form ETA-9035E is required through the iCERT Visa Portal System (iCERT System), which is accessible at http://icert.doleta.gov, unless an employer has a disability or lacks Internet access. Employers with a disability that prevents them from filing electronic applications or employers without Internet access can file the LCA by U.S. mail. Employers without Internet access MUST obtain prior permission to file their application by U.S. mail by submitting a written request to the following address:

Attention: Administrator
Office of Foreign Labor Certification
Employment & Training Administration
U.S. Department of Labor
200 Constitution Avenue, NW, Box PPII 12-200
Washington, DC 20210

Employers filing non-electronically due to disability must notify the Office of Foreign Labor Certification of the reason for the non-electronic filing at the time of submitting the application.

2. In accordance with 20 CFR part 655, Subpart H, either at the employer's principal place of business in the U.S. or at the place of employment, the employer must retain copies of the records required by Subpart H for a period of one (1) year beyond the last date on which any nonimmigrant worker is employed under the LCA or, if no nonimmigrant workers were employed under the LCA, one (1) year from the date the LCA expired or was withdrawn. Required payroll records for the nonimmigrant workers and other workers in the occupational classification, including the names and wage rates of such workers and the information on benefits offered, as required by 20 CFR 655.760(a)(6), shall be retained at the employer's principal place of business in the U.S. or at the place of employment for a period of three (3) years from the date(s) of the creation of the record(s), except that if an enforcement action is commenced, all payroll records shall be retained until the enforcement proceeding is completed through the procedures set forth in 20 CFR part 655, Subpart I. For a complete list of documents that must be retained and/or made available for public access, see 20 CFR 655.760.

Section A
Employment -Based Nonimmigrant Visa Information

1. Enter one of the following classification symbols to indicate the type of visa supported by this application: "**H-1B**," "**H-1B1 Chile**," "**H-1B1 Singapore**," or "**E-3 Australia**.**"** Select only one visa classification for all nonimmigrant workers employed pursuant to the LCA. When filing this application electronically, the iCERT System will provide a dropdown of the acceptable visa classification symbols.

   The **H-1B** visa allows an employer to temporarily employ foreign professional workers in the U.S. on a nonimmigrant basis in a specialty occupation or as a fashion model of distinguished merit and ability. Under 20 CFR 655.715, a specialty occupation requires the theoretical and practical application of a body of specialized knowledge and a bachelor's degree or the equivalent in the specific specialty (e.g., sciences, medicine and health care, education, biotechnology, business specialties, etc.).

   The **H-1B1-Chile** visa allows an employer to temporarily employ business professionals who are nationals of Chile under the Chile Free Trade Agreement.

   The **H-1B1-Singapore** visa allows an employer to temporarily employ business professionals who are nationals of Singapore under the Singapore Free Trade Agreement.

   The **E-3 Australia** visa allows an employer to temporarily employ business professionals who are nationals of Australia under Title V of the REAL ID Act of 2005 (Division B) in the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Tsunami Relief, 2005.

Section B
Temporary Need Information

1. Enter the title of the job opportunity for which the LCA is being sought. The employer's internal job title should be entered in this field.

   Note: The job title must be the same for all nonimmigrant workers working on a single LCA. The employer may file additional LCAs as needed.

2. Enter the six-digit Standard Occupational Classification (SOC)/Occupational Network (O*NET) code for the occupation, which most clearly describes the work to be performed. For example, the six-digit SOC code for a Computer Systems Analyst is 15-1121.

   Note: More information on SOC codes can be found at http://www.bls.gov/soc/.

3. Enter the occupational title associated with the SOC/O*NET code. For example, the occupational title associated with SOC/O*NET code 15-1121 is Computer Systems Analyst.

4. Indicate whether the position is full-time by marking "Yes" or "No." Although there is no regulatory definition for full-time employment for the H-1B, H-1B1, and E-3 programs, the Department generally considers 35 hours per week or more to be full-time.

   Note: If the position is part-time (less than 35 hours per week), the foreign worker(s) supported by the LCA must not regularly work more than the number of hours indicated (which may be a range of hours) on the United States Citizenship and Immigration Services (USCIS) Form(s) I-129 filed for the nonimmigrant(s).

   All foreign worker(s) under the LCA must be part-time if Item B.4 is marked "No"; all nonimmigrant worker(s) must be full-time if Item B.4 is marked "Yes." If the employer has both full-time and part-time nonimmigrant worker(s), then separate LCAs must be filed.

5. Enter the beginning date of the nonimmigrant worker's (workers') period of employment. The beginning date of employment cannot be more than 6 months from the date the LCA is submitted to the Department for processing. The beginning date of employment also cannot be prior to the date the LCA is submitted for processing. Use a month/day/full year (MM/DD/YYYY) format.

6. Enter the end date for the nonimmigrant worker's (workers') period of employment. The end date of employment cannot be more than three (3) years after the start date for H-1B LCAs and initial H-1B1 LCAs. The end date employment for E-3 LCAs and H-1B1 extensions cannot be more than two (2) years after the start date. Use a month/day/full year (MM/DD/YYYY) format.

7. This collection item contains two parts.

   First, enter the total unique number of worker positions being requested for certification. This total cannot be "0" (zero). For this total, count each worker once.

   Second, use collection Items B.7(a) through (f) to enter the number of foreign workers in each applicable USCIS-defined category under which the employer plans to file various Form I-129s for the foreign workers. The total worker positions requested for certification must be less than or equal to the sum total of the numbers entered in collection Items (a) through (f). Every box MUST be filled and a single worker may fit into multiple boxes, as appropriate.

   Note: If the employer does not plan to request nonimmigrant worker(s) in a particular category in Items (a) through (f), please enter "0" (zero), as appropriate. If an individual nonimmigrant worker fits into more than one category, indicate that in Items (a) through (f).

Section C
Employer Information

1. Enter the full legal name of the business, person, association, firm, corporation, or organization, i.e., the employer filing this application. The employer's full legal name is the exact name of the individual, corporation, LLC, partnership, or other organization that is reported to the Internal Revenue Service (IRS).

2. Enter the full trade name or "Doing Business As" (DBA) name, if applicable, of the business, person, association, firm, corporation, or organization, i.e., the employer filing this application.

3. Enter the street address of the employer's principal place of business.

4. If additional space is needed for the street address, use this line to complete the employer's street address.

5. Enter the city of the employer's principal place of business. If the city and country are the same, the name must still be entered in both fields.

6. Enter the State of the employer's principal place of business.

7. Enter the postal (zip) code of the employer's principal place of business.

8. Enter the country of the employer's principal place of business. If the city and country are the same, the name must still be entered in both fields.

   Note: This entry is for a country, not a county.

9. Enter the employer's province, if applicable.

10. Enter the area code and telephone number for the employer's principal place of business. Include country code, if applicable.

11. Enter the extension of the telephone number for the employer's principal place of business, if applicable.

12. Enter the nine-digit Federal Employer Identification Number (FEIN) as assigned by the IRS. **Do not enter a social security number.**

    Note: All employers, including private households, MUST obtain an FEIN from the IRS before completing this application. Information on obtaining an FEIN can be found at www.IRS.gov.

13. Enter the four to six-digit North American Industry Classification System (NAICS) code that best describes the employer's business, not the nonimmigrant worker's job. A listing of NAICS codes can be found at http://www.census.gov/epcd/www/naics.html.

Section D
Employer Point of Contact Information

An employer point of contact is an employee of the employer whose position authorizes the employee to provide information and supporting documentation concerning this LCA for nonimmigrant workers and to communicate with the Department on behalf of the employer. The employer point of contact should be the individual most familiar with the content of this application and circumstances of the nonimmigrant worker's (workers') employment.

Note: The employer point of contact information in this Section, specifically the name, telephone number, and email address, must be different from the attorney/agent information listed in Section E, unless the attorney is an employee of the employer.

1. Enter the last (family) name of the employer point of contact.

2. Enter the first (given) name of the employer point of contact.

3. Enter the middle name of the employer point of contact. In the absence of a middle name, enter N/A.

4. Enter the job title of the employer's point of contact.

5. Enter the business street address of the employer point of contact.

6. If additional space is needed for the street address, use this line to complete the street address.

7. Enter the city of the employer point of contact. If the city and country are the same, the name must still be entered in both fields.

8. Enter the state of the employer point of contact.

9. Enter the postal (zip) code of the employer point of contact.

10. Enter the country of the employer point of contact. If the city and country are the same, the name must still be entered in both fields.

11. Enter the province of the employer point of contact, if applicable.

12. Enter the area code and business telephone number of the employer point of contact. Include country code, if applicable.

13. Enter the extension of the telephone number of the employer point of contact, if applicable.

14. Enter the business e-mail address of the employer point of contact. Use a name@emailaddress.top-leveldomain format.

Section E
Attorney or Agent Information (if applicable)

Note: The information provided in this Section, specifically the name, telephone number, and e-mail address, must be different from the employer's point of contact information in Section D, unless the attorney is an employee of the employer. The employer authorizes the attorney or agent identified in this section to act on its behalf in connection with the filing of this application.

1. Identify whether the employer is represented by an attorney or agent in the process of filing this application. Only mark one box. If "Yes" complete the remainder of Section E. If "No" in question 1, skip 2 through 19 and continue to Section F.

2. Enter the last (family) name of the attorney/agent.

3. Enter the first (given) name of the attorney/agent.

4. Enter the middle name of the attorney/agent, if a middle name exists.

5. Enter the street address of the attorney/agent.

6. If additional space is needed for the street address, use this line to complete the attorney/agent's street address.

7. Enter the city of the attorney/agent. If the city and country are the same, the name must still be entered in both fields.

8. Enter the state of the attorney/agent.

9. Enter the postal (zip) code of the attorney/agent.

10. Enter the country of the attorney/agent. If the city and country are the same, the name must still be entered in both fields.

11. Enter the province of the attorney/agent, if applicable.

12. Enter the area code and telephone number of the attorney/agent. Include country code, if applicable.

13. Enter the extension of the telephone number of the attorney/agent, if applicable.

14. Enter the business e-mail address of the attorney/agent. Use a name@emailaddress.top-leveldomain format.

15. Enter the attorney/agent's law firm or business name.

16. Enter the attorney/agent's law firm or business nine-digit FEIN as assigned by the IRS. **Do not enter a social security number.**

17. Enter the attorney's State Bar number. If the attorney is licensed in more than one State, enter only one State Bar number. If the attorney is licensed in a state which does not issue State Bar numbers, enter "N/A".

    Note: The answers to questions 18 and 19 below should correspond to the same state for which a Bar number was provided in question 17, if any.

18. Enter the State of the highest court where the attorney is in good standing.

19. Enter the name of the highest State court where attorney is in good standing.

Section F
Employment and Wage Information

Note: In accordance with 20 CFR 655.730(c)(4), the employer must specify, among other requirements, the gross wage rate to be paid to each nonimmigrant, the prevailing wage for the occupation in the area of intended employment and the specific source relied upon to determine the prevailing wage, and the intended place(s) of employment. The employer must define the intended place(s) of employment with as much geographic specificity as possible. Each place of employment listed below must be the worksite or physical location where the work will actually be performed and cannot be a P.O. Box.

In accordance with 20 CFR 655.730(c)(5), the employer must identify all intended places of employment on the LCA, including intended places of employment which qualify as short-term placements under 20 CFR 655.735. A *place of employment* means the worksite or physical location where the work actually is performed by the H-1B, H-1B1, or E-3 nonimmigrant. See 20 CFR 655.715. A worksite location must be identified as an "intended place of employment" if the employer knows at the time of filing the LCA that it will place workers at the worksite, or should reasonably expect that it will place workers at the worksite based on: (1) an existing contract with a secondary employer or client, (2) past business experience, or (3) future business plans. The Department's electronic filing system will accept up to ten (10) physical locations with wage information and additional LCAs must be filed for any additional intended places of employment. If the employer is filing non-electronically and the employer intends that the work will be performed in more than one location, an attachment must be submitted in order to complete this section. If the employer has more than ten (10) intended places of employment at the time of filing this application, the employer must file as many additional Form ETA-9035 forms as are necessary to sufficiently list all intended places of employment.

a. Place of Employment Information 1

See the definition of "place of employment" in 20 CFR 655.715.

1. From the overall total worker positions entered in Item B.7, enter the estimated number of workers that will perform work at this place of employment.

2. For this intended place of employment, indicate whether the employer is placing the nonimmigrant worker(s) with a secondary entity. A secondary entity is another entity at which or with which LCA workers will be placed during the period of certification.

3. If "Yes" to Item F.2, provide the legal business name of the secondary entity (e.g., another entity) at which or with which the nonimmigrant worker(s) will be placed.

   Note: The entry must include the legal business name of the secondary entity. Any trade name or DBA name should also be entered, as space permits.

4. Enter the street address of the intended place of employment.

5. If additional space is needed for the street address, use this line.

6. Enter the city of the intended place of employment.

7. Enter the county of the intended place of employment. If there is no county designation or it is not known, please enter "N/A". Note: In the absence of a county, enter the appropriate parish or borough in this field. Do not enter a country in this field.

8. Enter the State/district/territory of intended employment.

9. Enter the postal (zip) code of the intended place of employment.

Wage Rate

10. Enter the wage to be paid to the nonimmigrant worker(s). If the wage offer is expressed as a range, enter the bottom of the wage range to be paid.

    Enter the top of the wage range to be paid to the nonimmigrant worker(s) in the section indicating "To" (required only for employers paying a wage range).

10a. Indicate whether the rate of pay unit is per hour, week, bi-week (every two weeks), month, or year.

Prevailing Wage

11. Enter the prevailing wage for the job opportunity.

11a**.** Indicate whether prevailing wage unit is per hour, week, bi-week (every two weeks), month, or year.

Prevailing Wage Source

NPWC PWD
For the prevailing wage source, if the employer is using a Prevailing Wage Determination (PWD) obtained from the Department of Labor's National Prevailing Wage Center (NPWC) for this LCA, provide the PWD tracking number in Item12a. Enter the tracking number in the following format using the appropriate numerical digits from the issued PWD: P-xxx-xxxxx-xxxxxx.

12a. Enter the NPWC PWD tracking number.

An Occupational Employment Statistics (OES) Prevailing Wage

For the prevailing wage source, if the employer is using a Bureau of Labor Statistics OES wage obtained from the iCERT System at http://icert.doleta.gov or the Foreign Labor Certification Online Data Center at www.flcdatacenter.com for this LCA, complete Items 13a and 13b.

13a. Enter OES wage level for the OES prevailing wage.

13b. Enter the year of the OES prevailing wage.

Example (For Instructional Purposes Only):

13. ■	**A PW obtained independently from the Occupational Employment Statistics (OES) Program**	
	a. Wage Level § ☐ I ☐ II ☐ III ■ IV ☐ N/A	b. Source Year § 2017

Another Legitimate Source (Other than OES) or an Independent Authoritative Source

For the prevailing wage source entry in this section, if the employer has a Collective Bargaining Agreement (CBA), Davis Bacon Act (DBA) wage, or McNamara O'Hara Service Contract Act (SCA) wage for this LCA, complete Items 14a and 14b.

For the prevailing wage source entry in this section, if the employer has another legitimate source or an independent authoritative source survey for this LCA, complete Item 14a by selecting "Other/ PW Survey" and complete Items14b, 14c, and 14d. In accordance with 20 CFR 655.731(a)(2)(ii)(C), another legitimate source is a source which: (1) Reflects the weighted average wage paid to workers similarly employed in the area of intended employment; (2) Reflects the median wage of workers similarly employed in the area of intended employment if the survey provides such a median and does not provide a weighted average wage of workers similarly employed in the area of intended employment; (3) Is based on the most recent and accurate information available; and (4) Is reasonable and consistent with recognized standards and principles in producing a prevailing wage.

In accordance with 20 CFR 655.715, an independent *authoritative source survey* means a survey of wages conducted by an independent authoritative source and published in a book, newspaper, periodical, loose-leaf service, newsletter, or other similar medium, within the 24-month period immediately preceding the filing of the employer's application. Such survey shall: (1) Reflect the average wage paid to workers similarly employed in the area of intended employment; (2) Be based upon recently collected data—e.g., within the 24-month period immediately preceding the date of publication of the survey; and (3) Represent the latest published prevailing wage finding by the authoritative source for the occupation in the area of intended employment. An independent authoritative source means a professional, business, trade, educational or governmental

association, organization, or other similar entity, not owned or controlled by the employer, which has recognized expertise in an occupational field.

14a. Indicate the prevailing wage source type.

14b. Enter the year of the prevailing wage source. For unpublished surveys issued to or produced for the employer, enter the year.

14c. For a prevailing wage survey, enter the survey producer or publisher (e.g., survey company name).

14d. For a prevailing wage survey, enter the title or source of the prevailing wage survey (e.g., name of the survey instrument).

14	**A PW obtained using another legitimate source (other than OES) or an independent authoritative source**	
■	a. Source Type *(check one):* § ☐ CBA ☐ DBA ☐ SCA ■ Other PW Survey	b. Source Year § 2017
	c. If responded "Other/PW Survey" in question 14.a, enter the name of the survey producer or publisher § XYZ Survey Publisher	
	d. If responded "Other PW Survey" in question 14.a, enter the title or source of the PW survey § Survey of Computer Systems Analysts	

Section G
Employer Labor Condition Statements

The employer must read and agree to statements (1) through (4) below and demonstrate that agreement by marking "Yes" to Item 1 in Section G of the Form ETA-9035/9035E and by signing the application. The employer agrees to develop and maintain documentation supporting labor condition statements (1) through (4) as specified in 20 CFR 655.731 through 655.734, and to make this documentation available to Department of Labor officials upon request. The employer is required to make available for public examination a copy of the LCA and necessary supporting documentation as specified in 20 CFR 655.760 within one (1) working day after the date on which the application has been filed with the Department of Labor. This documentation must be retained for public examination at the place of employment or the employer's principal place of business as specified in Section I of this form.

(1) **Wages:** The employer attests that H-1B, H-1B1, or E-3 nonimmigrant workers will be paid wages which are at least the higher of the actual wage level paid by the employer to all other individuals with similar experience and qualifications for the specific employment in question or the prevailing wage level for occupational classification in the area of intended employment. By marking "Yes" to Item 1 of Section G, the employer also attests that it will pay these nonimmigrant workers the required wage for time in nonproductive status due to a decision of the employer or due to the nonimmigrant worker's lack of a permit or license. The employer further attests that these nonimmigrant workers will be offered benefits and eligibility for benefits on the same basis, and in accordance with the same criteria, as offered to U.S. workers. The employer shall not make deductions to recoup a business expense(s) of the employer, including attorney fees and other costs connected to the performance of H-1B, H-1B1, or E-3 program functions, which are required to be performed by the employer. This includes expenses related to the preparation and filing of this LCA and related visa petition information. See 20 CFR 655.731.

(2) **Working Conditions:** The employer attests that the employment of H-1B, H-1B1 or E-3 nonimmigrant workers in the named occupation will not adversely affect the working conditions of similarly employed U.S. workers. The employer further attests that nonimmigrant workers will be afforded working conditions on the same basis, and in accordance with the same criteria, as offered to U.S. workers. See 20 CFR 655.732.

(3) **Strike, Lockout, or Work Stoppage:** The employer attests that on the date the application is signed and submitted, there is not a strike, lockout, or work stoppage in the course of a labor dispute in the occupational classification in the area of intended employment and that, if such a strike, lockout, or work stoppage occurs after the application is submitted, the employer will notify the Employment & Training Administration (ETA) within three (3) days of such occurrence; in that event, the application will not

be used in support of a petition filing with the USCIS for H-1B, H-1B1, or E-3 nonimmigrant workers to work in the same occupation at the place of the employment until ETA determines the strike lockout or work stoppage has ceased. See 20 CFR 655.733.

(4) **Notice:** The employer attests that notice of the LCA filing was provided no more than 30 days before filing of this LCA or will be provided on the day this LCA is filed to workers employed in the occupational classification. Notice of the application shall be provided to workers through the bargaining representative, or where there is no such bargaining representative, notice of the filing shall be provided either through physical posting in conspicuous locations where H-1B, H-1B1, or E-3 nonimmigrant workers will be employed, or through electronic notification to employees in the occupational classification for which nonimmigrant workers are sought. Notice shall be provided no more than 30 days before the date the LCA is filed and no later than the day the LCA is filed and remain posted for 10 days, except that if employees are provided individual, direct notice by e-mail, notification need only be given once. Notice documentation shall be maintained in the employer's records.
Notice shall be made in accordance with the requirements of 20 CFR 655.734 and contain the following statement: "Complaints alleging misrepresentation of material facts in the labor condition application and/or failure to comply with the terms of the labor condition application may be filed with any office of the Wage and Hour Division of the United States Department of Labor." The WH-4 complaint form and a listing of Wage and Hour Division offices can be obtained at www.dol.gov/whd. In addition, if the employer is an H-1B dependent employer or a willful violator, and the LCA is not being used only for exempt H-1B nonimmigrant workers, the notice shall be made in accordance with the requirements of 20 CFR 655.734 and shall contain the following statement: "Complaints alleging failure to offer employment to an equally or better qualified U.S. applicant or an employer's misrepresentation regarding such offers of employment may be filed with U.S. Department of Justice, Civil Rights Division, Immigrant and Employee Rights Section, 950 Pennsylvania Avenue, NW # IER, NYA 9000, Washington, DC, 20530, Telephone: 1(800) 255-8155 (employers); 1(800) 255-7688 (employees); Internet address: http://www.justice.gov ." See 20 CFR 655.734 and 655.760.
The employer further attests that each nonimmigrant worker employed pursuant to the application will be provided with a copy (or original, as appropriate) of the certified Form ETA-9035E, or Form ETA-9035 (if applicable). As stated above for H-1B, H-1B1, or E-3 nonimmigrant workers, the employer must provide the certified LCA to the nonimmigrant worker, who must follow the H-1B, H-1B1, or E-3 procedures of USCIS and the Department of State. The notification shall be provided no later than the date the nonimmigrant reports to work at the place of employment. See 20 CFR 655.734.

1. Indicate whether the employer has read and agrees to the labor condition statements (1) through (4) above, regarding wages, working conditions, strike, lockout or work stoppage, and notice. The employer must agree to all four labor condition statements listed as (1) to (4). **Please note that marking "Yes" indicates that the employer has read and agrees to the above-listed labor condition statements.**

Section H
Additional Employer Labor Condition Statements – This section is to be completed by H-1B Employers ONLY

All H-1B employers are required to complete Section H in order for an LCA to be processed. See 20 CFR 655.736 for more detailed guidance as to what constitutes an "H-1B dependent employer" or a "willful violator."

a. Subsection 1
Note: The determination of whether an employer is H-1B dependent is based on the ratio between the employer's total workforce employed in the U.S., as measured according to full-time equivalent employees, and the employer's H-1B nonimmigrant employees including both full-time and part-time H-1B employees. See 20 CFR 655.736. The following table can be used to determine whether the employer is an H-1B dependent employer:

TOTAL WORKFORCE EMPLOYED IN THE U.S. (FULL-TIME EQUIVALENT EMPLOYEES)	TOTAL H-1B NONIMMIGRANT EMPLOYEES
1 to 25	8 or more
26 to 50	13 or more
51 or more	15% or more of the employer's total workforce employed in the U.S.

1. Indicate whether the employer is H-1B dependent at the time of filing. The employer is H-1B dependent if the number of H-1B nonimmigrant workers employed by the employer as a proportion of the total number of full-time equivalent employees employed in the United States matches the chart above.

   If an employer marks "No" and is or becomes H-1B dependent, the submitted LCA must not be used in support of a new petition or extension of a petition for an H-1B nonimmigrant worker. By marking "No," the employer also acknowledges that if it uses this application to support a new petition or extension of a petition despite its invalidity, it is required to comply with the Additional Employer Labor Condition Statements in Subsection 2 of Section H.

2. Indicate whether the employer is a willful violator at the time of filing. The employer is a willful violator if the employer has been found during the five (5) years preceding the date of the application (and after October 20, 1998) to have committed a willful violation or a misrepresentation of a material fact.

   If an employer marks "No" and is found, prior to the date of filing, to have committed a willful violation or a misrepresentation, the submitted LCA must not be used in support of a new petition or extension of a petition for an H-1B nonimmigrant worker. By marking "No," the employer also acknowledges that if it uses this application to support a new petition or extension of a petition despite its invalidity, it is required to comply with the Additional Employer Labor Condition Statements in Subsection 2 of Section H.

3. If Yes to Item H.1 and/or Item H.2, indicate whether the employer intends to use this application ONLY to support H-1B petitions or extensions of status for H-1B nonimmigrant workers who are exempt, i.e., receive wages at a rate equal to at least $60,000 per year, or have attained a Master's degree (or equivalent or higher degree) in a specialty related to the employment. The employer also agrees to maintain documentation required by 20 CFR 655.737. **If an employer marks "Yes," the employer acknowledges that if it uses this application in support of a petition or extension of a petition of an H-1B nonimmigrant who is not exempt, it is required to comply with the Additional Employer Labor Condition Statements in Subsection 2 of Section H with respect to all H-1B nonimmigrant workers supported by this application.**

4. If the employer responded "Yes" to an exemption in Item H.3, indicate the basis (or bases) of the exemption. Check a box for either $60,000 or higher annual wage, or Master's Degree or higher in related specialty, or the box for "Both" if both exemptions are applicable. All workers subject to the LCA must meet the exemption(s) claimed.

5. If the employer marked "Master's Degree or higher in related specialty" in Item H.4, indicate by marking "Yes or No" whether the employer has completed and attached Appendix A to this LCA. Instructions for completing Appendix A can be found at the end of this document.

   If the employer is seeking an exemption solely based on the H-1B nonimmigrant worker(s) receiving wages at an annual rate equal to at least $60,000 or higher, then mark "N/A".

b. Subsection 2

All employers that are (1) H-1B dependent (as defined above) and/or (2) have been found to have committed a willful violation or a misrepresentation of a material fact during the five (5) year period preceding the date of this application, **must read and agree to statements (A) through (C) and demonstrate that agreement by marking "Yes" in Subsection 2 of Section H of this application**. The employer agrees to develop and maintain documentation supporting labor condition statements (A) through (C) as specified in 20 CFR 655.738 and 655.739, and to make this document available to Department officials upon request. The employer is required to make available for public examination a copy of the LCA and necessary supporting documentation as specified in 20 CFR 655.760 within one (1) working day after the date on which the application has been filed with the Department. This documentation must be retained for public examination at the place of employment in the U.S. and/or the employer's principal place of business in the U.S. as specified in Section I of this form. The employer agrees:

A. Displacement: The employer will not displace any similarly employed U.S. worker in an essentially equivalent job in its own workforce within the period beginning 90 days before and ending 90 days after the date of filing a petition for an H-1B nonimmigrant worker supported by this application.

B. Secondary Displacement: The employer will not place any H-1B nonimmigrant worker employed pursuant to this application at another employer's worksite where there are indicia of an employment relationship between the nonimmigrant(s) and that other/secondary employer UNLESS the employer applicant first makes an inquiry as to whether the other employer has displaced or intends to displace a similarly employed U.S. worker in an essentially equivalent job within the period beginning 90 days before and ending 90 days after the placement, and the employer applicant has no contrary knowledge.

If the other employer displaces a similarly employed U.S. worker during such period, the displacement will constitute a failure to comply with the terms of the LCA and the employer applicant may be subject to civil money penalties and debarment. See 20 CFR 655.738.

C. Recruitment and Hiring: Prior to filing any petition for an H-1B nonimmigrant worker pursuant to this application, the employer took or will take good faith steps meeting industry-wide standards to recruit U.S. workers for the job for which the nonimmigrant is sought, offering compensation at least as great as required to be offered to the H-1B nonimmigrant. The employer will (has) offer(ed) the job to any U.S. worker who (has) applied and is equally or better qualified than the H-1B nonimmigrant worker.

Under the Immigration and Nationality Act (INA) Section 212 (n)(1)(G)(ii), 8 U.S.C. 1182, the "recruitment and hiring" labor condition statement does not apply to the employment of an H-1B nonimmigrant worker who is a "priority worker" (defined as a person with extraordinary ability, or outstanding professors or researchers, or certain multi-national executives or managers) within the meaning of Section 203 (b)(1)(A), (B), or (C) of the INA, 8 U.S.C. 1153.

6. Indicate whether the employer has read and agrees to the additional employer labor conditions statements in Subsection 2(A) through (C). The employer must agree to all three labor condition statements of Section H, subsection 2. Answer this question only if the employer marked "Yes" to either or both questions in Item H.1 or Item H.2 (indicating that the employer is either an H-1B dependent employer or a willful violator, or both) and, also, the employer marked "No" to the question in Item H.3 ("No" to exempt H-1B nonimmigrant workers).

Section I
Public Disclosure Information

1. Indicate whether the employer's required public disclosure information will be located at the employer's principal place of business in the U.S. AND/**OR** the place of employment in the U.S. The employer may select more than one box.

If the employer elects to store the public access file electronically, the employer must make the file available and accessible for government or public inspection upon request, at the particular location(s) provided in Section I of the Form ETA-9035/9035E.

Section J
Notice of Obligations

Note: If the employer is submitting this form non-electronically, the employer must sign and date the application prior to submission. If submitting this form electronically, the employer must sign and date the application immediately upon receipt of the certified application and before submission to USCIS.

Items J. (A) through (C). Read this Section.

1. Enter the last (family) name of the person with authority to sign as the employer.

2. Enter the first (given) name of the person with authority to sign as the employer.

3. Enter the middle name of the person with authority to sign as the employer, if applicable.

4. Enter the job title of the person with authority to sign as the employer.

5. The person with authority to sign as the employer must sign the application. **Read the entire application and verify all contained information prior to signing.**

For paper filings, the application should be signed prior to submission to the Department. For electronic submissions, the employer will sign and date the LCA after receiving certification from the Department.

6. The person with authority to sign as the employer must date the application. Use a month/day/full year (MM/DD/YYYY) format.

Section K
LCA Preparer

This section must be completed if the preparer of this LCA is a person other than the one identified in either Section D (employer point of contact) or E (attorney or agent) of this application. For example, an employee of the attorney (e.g., paralegal) would complete the LCA preparer section. If the employer or attorney/agent contact listed in section D or section E was the person preparing and submitting the LCA, then this section will be left blank.

1. Enter the last (family) name of the person preparing this LCA by or on behalf of the employer.
2. Enter the first (given) name of the person preparing this LCA by or on behalf of the employer.
3. Enter the middle name of the person preparing this LCA by or on behalf of the employer, if a middle name exists.
4. Enter the Firm/Business name of the person preparing this LCA by or on behalf of the employer.
5. Enter the e-mail address of the person preparing this LCA by or on behalf of the employer. The entry must be in the format name@emailaddress.top-level domain.

Section L
U.S. Government Agency User ONLY

Read this section. No entries required.

Section M
Signature Notification and Complaints

Read this section. No entries required.

Section N
OMB *Paperwork Reduction Act (1205-0*310)
Read this section. No entries required.

Form ETA-9035/9035E Appendix A
H.5. Attainment of Educational Degree for "Exempt" H-1B Nonimmigrants

H-1B Dependent Employers or Willful Violator Employers ONLY - For Master's or Higher Degree Exemptions ONLY

For the LCA that you are filing, all workers subject to the LCA must meet the same exemption(s) claimed in Section H.

You must complete and attach Appendix A with documentation for any H-1B nonimmigrant worker subject to the application if the statutory exemption for that worker:

- Will be based **only** on the Master's or higher degree exemption.

Do NOT complete and attach Appendix A with documentation for an H-1B nonimmigrant worker subject to the application if the statutory exemption for that worker:

- Will be based on the $60,000 annual wage exemption; or

- Will be based on both exemptions (i.e. both the Master's or higher degree and the $60,000 annual wage).

Pursuant to 20 CFR 655.738 and 655.739, an employer that is H-1B dependent or a willful violator is generally subject to the attestation obligations regarding displacement and recruitment of U.S. workers. However, these additional statutory obligations do not apply to an employer where the LCA is used only for the employment of "exempt" H-1B nonimmigrant worker(s), as described in 20 CFR 655.737, who either (1) receives wages (including cash bonuses and similar compensation) at an annual rate equal to at least $60,000; or (2) attains a master's or higher degree (or its equivalent) in a specialty related to the intended employment.

For purposes of claiming the exemption, "master's or higher degree (or its equivalent)" means a foreign academic degree from an institution which is accredited or recognized under the law of the country where the degree was obtained, and which is equivalent to a master's or higher degree issued by a U.S. academic institution. The equivalence to a U.S. academic degree cannot be established through experience or through demonstration of expertise in the academic specialty (*i.e.,* no "time equivalency" or "performance equivalency" will be recognized as substituting for a degree issued by an academic institution). 20 CFR 655.737(d)(1).

A "specialty related to the intended employment" means that the academic degree is in a specialty which is generally accepted in the industry or occupation as an appropriate or necessary credential or skill for the person who undertakes the employment in question. A "specialty" which is not generally accepted as appropriate or necessary to the employment would not be considered to be sufficiently "related" to afford the H-1B nonimmigrant status as an "exempt" H-1B nonimmigrant. 20 CFR 655.737(d)(2).

Where the employer has designated that the LCA will be used to support H-1B petition(s) and/or request(s) for extension of status for "exempt" H-1B nonimmigrant workers based on attainment of a master's or higher degree (or its equivalent) in a specialty related to the intended employment, the employer must fully complete and submit the Form ETA-9035, Appendix A. The employer must disclose the educational attainment information for all "exempt" H-1B nonimmigrant workers who will be employed under the LCA for which the employer is claiming the exemption because the worker has a "master's or higher degree (or its equivalent)." Where multiple H-1B nonimmigrant workers attained the same degree in the same field of study from the same institution on the same date, the employer is only required to disclose the educational attainment information once on the Form ETA-9035, Appendix A. Because each of the initial five (5) educational attainment information sections is identical, the instructions for completing the collection elements are only described one time below. Each field within the educational attainment information section must be completed.

NOTE: If the employer will claim the exemption for workers with a "master's or higher degree or higher (or its equivalent)" for more than five (5) workers with different educational attainment information, the employer must report as many additional sections of educational attainment information as are necessary to cover all "exempt" H-1B nonimmigrant workers who will be employed under the LCA.

a. Educational Attainment Information 1

1. Enter the number of H-1B nonimmigrant workers that the H-1B dependent or willful violator employer will seek exemption status based on attainment of a master's or higher degree (or its equivalent) in a specialty related to the intended employment who attended the same institution with the same field of study and date of degree. The total number of H-1B nonimmigrant workers entered in this field must not be greater than the entry for "Total Worker Positions Being Requested for Certification" provided in Item B.7, Form ETA-9035. Where multiple sections of educational attainment information are entered, the sum of the number of H-1B nonimmigrant workers entered in this field in each section must not be greater than the entry for "Total Worker Positions Being Requested for Certification" provided in Item B.7, Form ETA-9035.

2. Enter the full name of the accredited or recognized institution (e.g., college or university) that awarded the degree to the H-1B nonimmigrant worker(s).

3. Enter the field of study in which the degree was awarded to the H-1B nonimmigrant worker(s).

4. Enter the date on which the degree was awarded to the H-1B nonimmigrant worker(s) using MM/DD/YYYY format (e.g., 06/01/2017).

NOTE: The employer is required to provide documentation at the time of filing which substantiates the academic information provided. The documentation is limited to the following: a copy of the degree, a transcript, or an official letter from the academic institution which granted the degree. All documentation must be provided at the time of the application's filing for consideration with the application. Any document in a foreign language must be accompanied by a full and complete English language translation.