AMERICAN LEGACY
STUCCO & STONE

BENEFIT GUIDE

From Healthcare to Retirement — We've Got You Covered

Many of our resources are available in English and Spanish.

Please use whichever version best serves you.

English

Spanish

We are happy to help in any language.

If you require assistance, please email us at HR@american-stucco.com.

Contact Us

Investing in You

To the Entire American Legacy Team,

Our success at American Legacy Stucco and Stone ("American Legacy" or "the Company") is built on the hard work and dedication of our employees. Each of you plays an important role in the quality of our projects and the strength of our reputation, and we want to make sure you feel valued and supported in return.

This Benefit Guide is one way we demonstrate that commitment. The benefits offered here are designed to protect you and your family, support your health and well-being, and provide peace of mind. Whether it's medical coverage, financial wellbeing, or resources to help you through life's challenges, these programs are here to help you thrive at work and at home.

We know that choosing benefits can feel overwhelming, but we encourage you to take time to review the options and ask questions. Our goal is to make sure these plans truly serve your needs, so you can focus on your work and your future with confidence.

Thank you for the dedication and professionalism you bring to American Legacy every day. We're proud to invest in you — because when our people succeed, our company succeeds.

— American Legacy Stucco & Stone Leadership

Guide Contents

DISCLAIMER

This employee benefits guide highlights the main features of your benefit programs. It is intended to help you choose the benefits that are best for you.

This brochure does not include all rules and details, including limitations and exclusions for these plans. the terms of your benefit plans are governed by legal documents, including insurance contracts.

Should there be any inconsistencies between this brochure and the legal plan documents. The plan documents are the final authority.

Health Insurance ELIGIBILITY

American Legacy is proud to support the health and well-being of our employees and their families by offering comprehensive medical coverage to help manage healthcare costs and provide peace of mind. The following section explains eligibility, coverage start dates, and how to enroll.

Benefit Plan Year

American Legacy's benefit plan year begins on January first and runs through December 31.

Our 2026 plan year is
01/01/2026 - 12/31/2026

Employee Eligibility

All full-time employees working an average of 30 or more hours per week are eligible for health insurance on the first day of the month **following 60 days** of employment.

Dependent Eligibility

To be eligible for enrollment in your benefit plans, the dependent must be:

- Your legal spouse or domestic partner
- Your biological child, step child, legally adopted child or a child for whom you, the employee, are a legal guardian up to their 26th birthday - or beyond if they cannot work to support themselves due to mental or physical disabilities.

Health Insurance
PLAN DESIGN

American Legacy offers three medical plans administered through EMI and Blue Cross Blue Shield (BCBS). These options range from free or low-cost to higher-cost coverage, giving employees flexibility to choose the plan that best fits their needs. While some plans allow you to see any provider, you'll save money and maximize your benefits by using in-network providers.

EMI HEALTH™ + BlueCross BlueShield

What is MEC?

MEC stands for **Minimum Essential Coverage**. It's a type of health insurance that meets the basic requirements of the Affordable Care Act (ACA) for having health coverage. MEC plans are designed to cover preventive services like annual checkups, screenings, and immunizations at no cost to you.

It's important to know that while MEC satisfies the ACA requirement, it does not provide the same level of protection as a full medical plan. MEC generally does not cover hospital stays, surgeries, or major medical expenses.

American Legacy contributes toward the cost of employee health coverage and ensures that **the basic MEC plan is available free of charge to all eligible employees. This guarantees every team member access to essential preventive care, even if they choose not to enroll in one of the more comprehensive medical plan options.**

Health Insurance Plan Optio

Summary of Benefits	MEC Basic	MEC Enhanced
Calendar-Year Deductible	None	None
Max Out of Pocket	None	None
Coinsurance	None	None
TeleMedicine	$0 Copay	$0 Copay
Preventive Care	Covered 100%	Covered 100%
Primary Care Visit	Not Covered	$20 Copay (3** incl. Spec)
Specialist Visit	Not Covered	$50 Copay (3** incl. PCP)
Urgent Care	Not Covered	$50 Copay
Lab & X-Ray (Major, CT, MRI)	Not Covered	$250 Copay (1**)
Lab & X-Ray (Radiology, Lab)	Not Covered	$50 Copay (3**)
Outpatient Services	Not Covered	Covered 100%**
Inpatient Services (Hospital)	Not Covered	Not Covered
Emergency Room	Not Covered	Not Covered
Prescription/Mail Order*		
Tier 1 - Generic	Discount Only	10%
Tier 2 - Preferred	Discount Only	50%
Tier 3 - Non-Preferred	Discount Only	Discount Only
Speciality Prescriptions		
Tier 1 - Generic	Not Covered	Not Covered
Tier 2 - Preferred	Not Covered	Not Covered
Tier 3 - Non-Preferred	Not Covered	Not Covered
Your Cost per Pay Period		
Employee Only	**0.00**	**17.08**
Employee + Spouse	**6.92**	**32.08**
Employee + Child(ren)	**10.15**	**38.54**
Employee + Family	**17.08**	**51.23**

*ACA mandated preventive prescriptions are covered in full on all plans

**Subject to annual limits

ons

EMI BCBS ($6,500 / $8,500)

In-Network	Out-of-Network	
$6,500 / $13,000	$13,000 / $26,000	Calendar-Year Deductible
$8,500 / $17,000	$17,000 / $34,000	Max Out of Pocket
100% after deductible	50% after deductible	Coinsurance
$0 Copay w/ Recuro	Not Covered	TeleMedicine
Covered 100%	Not Covered	Preventive Care
$10-$40 Copay	50% after deductible	Primary Care Visit
$20-$75 Copay	50% after deductible	Specialist Visit
$100 Copay	50% after deductible	Urgent Care
100% after deductible	50% after deductible	Lab & X-Ray (Major, CT, MRI)
Covered 100%	50% after deductible	Lab & X-Ray (Radiology, Lab)
100% after deductible	50% after deductible	Outpatient Services
100% after deductible	50% after deductible	Inpatient Services (Hospital)
100% after deductible	$400 Copay	Emergency Room
		Prescription/Mail Order*
$20 Copay after ded.	10%	Tier 1 - Generic
$75 Copay after ded.	50%	Tier 2 - Preferred
$150 Copay after ded.	Discount Only	Tier 3 - Non-Preferred
		Speciality Prescriptions
25%, $150 max per Rx		Tier 1 - Generic
25%, $250 max per Rx		Tier 2 - Preferred
30%, $500 max per Rr		Tier 3 - Non-Preferred
		Your Cost per Pay Period
182.22		Employee Only
396.61		Employee + Spouse
357.64		Employee + Child(ren)
611.02		Employee + Family

*ACA mandated preventive prescriptions are covered in full on all plans

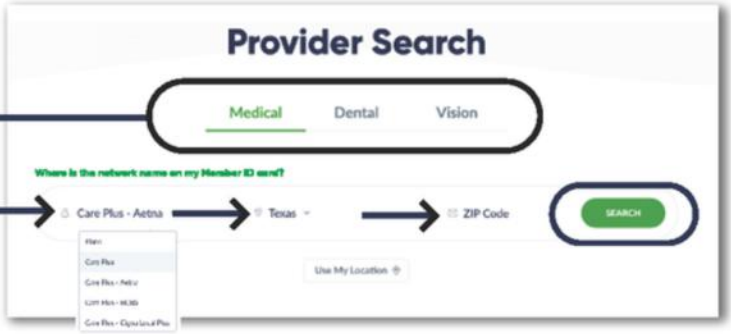
Online Services

Finding a Provider

As a member of EMI Health, you can take advantage of a large choice of in-network providers locally and nationally. To find an in-network provider, follow these steps.

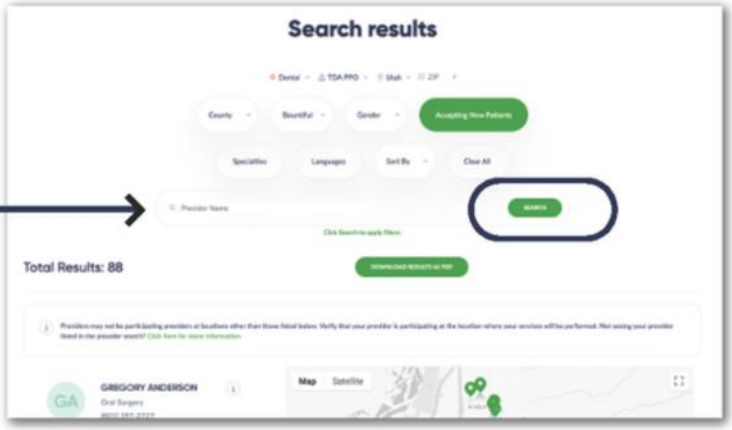
1. Go to **emihealth.com** and click on **+ FIND A PROVIDER** along the upper part of the home page, or use the green button below.

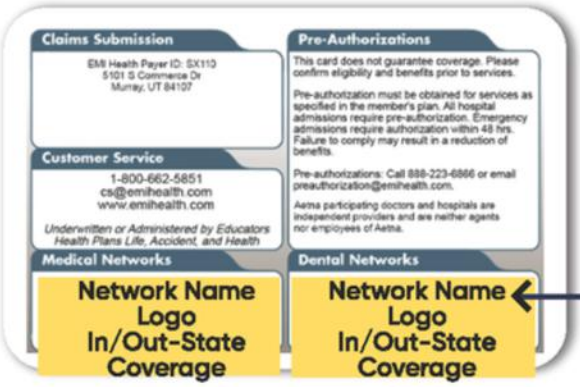
2. Click on either the **MEDICAL, DENTAL,** or **VISION** tab, Choose your **NETWORK NAME** (see note below on how to locate your network) from the drop down menu, Choose your **STATE**, and click **SEARCH**.



3. Scroll down to see a list of participating providers along with their contact information.

   If you'd prefer to search for a specific provider, enter the **PROVIDER NAME** in the field and click the **SEARCH** button.





Locating your NETWORK NAME on your ID Card:

You can find the searchable **Network Name** within each category (medical/dental/vision) of your subscribed types of coverage. If applicable, there will be network logos for "within state" and "out-of-state" coverage networks.

Questions? **1 (800) 662-5851**

Your benefits. *Anytime, Anywhere,*

The EMI Health App

EMI HEALTH

BlueCross BlueShield

Download the app and log in using your My EMI Health username and password. If you haven't registered your account, you can do so in the app or online at **emihealth.com.**

Available on the App Store

ANDROID APP ON Google play

ID Card

Access your ID Card from anywhere at any time.

Claims

View claim details and Explanation of Benefits (EOB).

Plan Information

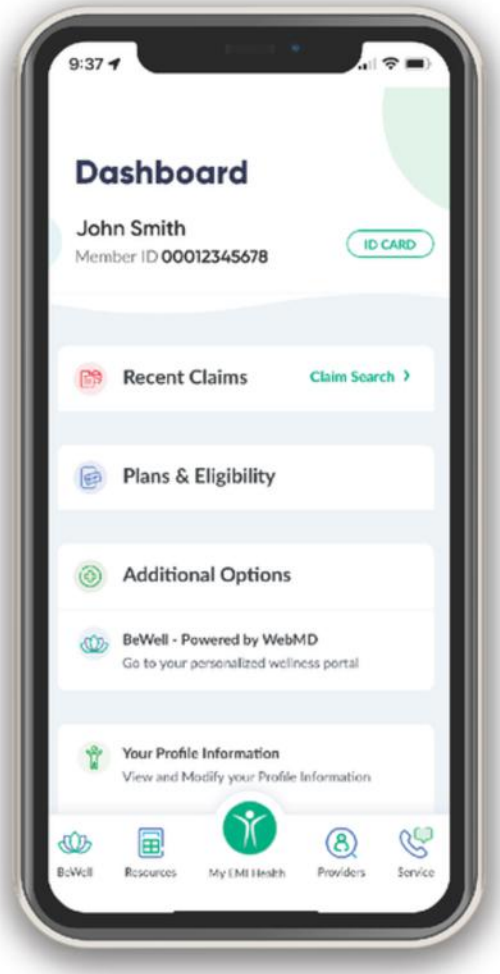
View and download your plan grids.

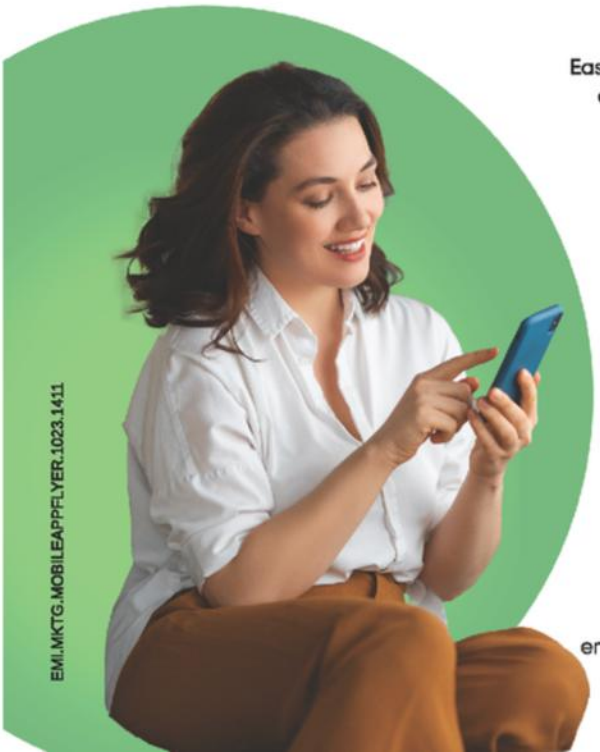
Profile

Update information like email address, password, or security.

Provider Search

Easily search for participating providers along with their contact information.





EMI.MKTG.MOBILEAPPFLYER.1023.1411

Scan this QR code with your phone to download.

emihealth.com | (800) 662-5851 | 5101 S Commerce Drive Murray, UT 84107

TeleMedicine

Reach a doctor 24/7/365

Some **70% of doctor visits can be handled over the phone**, and 40% of urgent care visits can be managed using TeleMedicine. Save time and money while still getting the treatment you need through EMI Health TeleMed offered through Recuro Health (formerly WellVia).

How do I use it?

Telemedicine doctors diagnose acute, non-emergent medical conditions and prescribe medications when clinically appropriate. Speak with a doctor anytime and pay no consultation fee rather than paying the high costs associated with office, urgent care, and ER visits.

Common Conditions

Acid Reflux + Allergies + Asthma
Bladder Infection + Bronchitis + Cold/Flu
Constipation + Cough + Ear Pain Fever
Gout + Headache + Hemorrhoids + High Blood Pressure + Joint Pain + Nausea
Pink Eye + Rashes + Sinus Conditions
Sore Throat + UTIs + Yeast Infections

TeleMedicine

Making Advanced Healthcare **Accessible**™

- 10 Min or Less Virtual Urgent Care
- Primary Care Visits in 24-48hrs
- 1:1 Patient/Doctor Relationships
- Prioritizes Prevention Over Sick-Care
- Healthier Outlook = Lower Costs

RECURO HEALTH

Download The App To Your Device

Available on the App Store

Get it on Google play

GoodRx

How GoodRx Works

Compare Prices

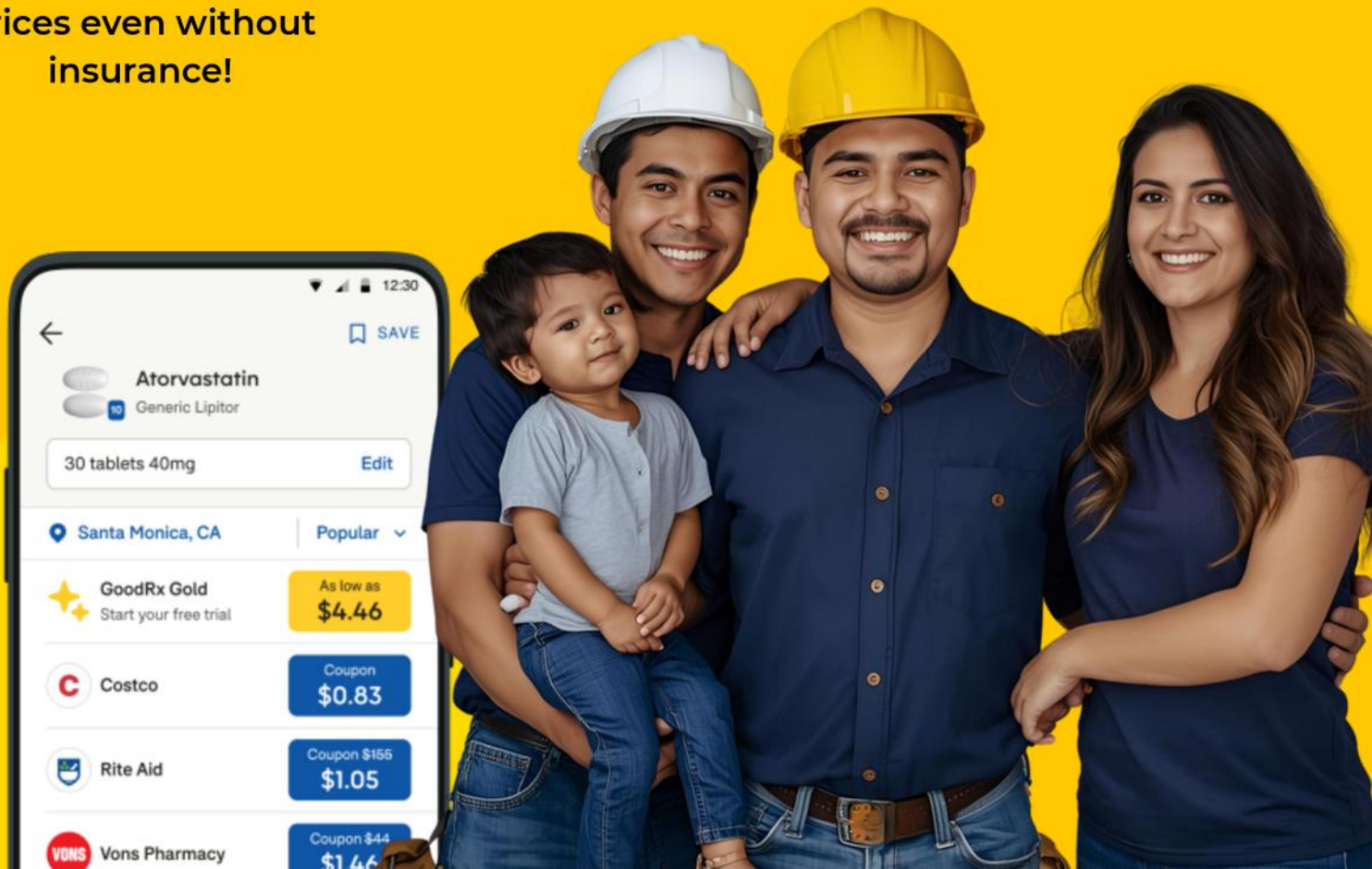
Drug prices vary by pharmacy. Use GoodRx to find current prices and discounts that are **often lower than cash prices even without insurance!**

Get Free Coupons

GoodRx Coupons can help you pay less than the cash price for your prescription.

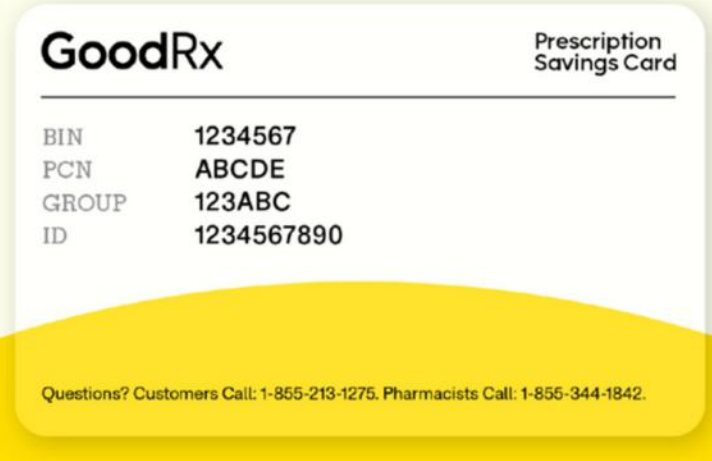
Use at Pharmacy

It's easy. Just bring your free coupon to the pharmacy when picking up your prescription.



GoodRx

Save up to 80% at over 70,000 pharmacies nationwide.



No insurance necessary!

Available on the App Store

Get it on Google play

Download The GoodRx App Today

Paid Time Away

Time away from work is an important part of staying healthy, balanced, and productive. American Legacy provides paid time off, sick time, and holiday benefits to give you the flexibility to rest, recharge, and take care of personal needs. Please see your handbook for full details.

Paid Sick Time

All American Legacy employees earn **1 hour of paid sick leave for every 30 hours** they work. Paid sick leave balances are updated weekly and can be found on your pay statements or in your Paylocity app.

Paid TIme Off

Administrative employees who work at least 30 hours each week earn .77 hours of paid time off each pay period (40-hours over the course of a full year).

Paid Holidays

American Legacy generally observes 6 paid holidays per year. Due to the variable nature of our business, not all employee groups qualify for paid holiday leave. Please reference the employee handbook for details.

Requesting Time Off

All time-off requests must be submitted through the Paylocity app for your manager to review and approve. Your manager or HR are available to assist if you don't know how.

Retirement

American Legacy Stucco & Stone offers a Profit Sharing Plan to help you save for the future. **The plan is funded entirely by the Company — you don't make contributions.** Each year, the Company may choose to add money to the plan based on business performance. If a contribution is made, it's shared among eligible employees according to the plan's rules.

Eligibility

All employees become eligible to participate in the retirement plan after completing **one year of service with at least 1,000 hours** worked.

Breaks in service (fewer than 501 hours in a year) may delay or affect eligibility.

If you are rehired, prior service may count toward eligibility unless it was disregarded under break-in-service rules.

Vesting Schedule

Employer contributions become yours over time based on years of service. You're 20% vested after 2 years, with an additional 20% each year, reaching **100% after 6 years.** Breaks in service may affect vesting. You keep the vested portion of your account if you leave the Company.

Have Questions?

American Legacy's retirement plan is self-administered. **Please review your Summary Plan Description** for full details and send any questions you may have to Human Resources at HR@american-stucco.com.

PROVIDED BY

PROVIDED BY

modrnHR
CONSULTING & TRAINING

+1-662-MODRNHR
+1-662-663-7647
modrnHR.com

AMERICAN LEGACY STUCCO & STONE

HEALTH PLAN ENROLLMENT

241

1 ACTIVE EMPLOYEE INFORMATION

First Name			Last Name		
Cell Phone			Email		
Address			City, State	Zip	
Position			Hire Date	Eligibile	
Social Sec			Birth Date	Sex	

2 HEALTH INSURANCE PLAN OPTIONS

Health Plan Selected	Coverage Level	Your Cost per Pay Period

FAMILY MEMBERS TO BE COVERED

Relationship	Full Legal Name	Sex	Birth Date	Social Security	Address

OTHER INSURANCE INFORMA

ENROLL or WAIVE

English →

Spanish →

3 CERTIFICATION & ACKNOWLEDGEMENTS

I hereby apply for coverage to which I may be entitled or to which i may become entitled under the terms of agreements, including binding arbitration provisions, in the policies issues by EMI Health. I accept the terms of group agreement between my employer and the plan and appoint my employer to act as agent on my behalf. I authorize the deduction from my earnings of any contribution I am required to make towards the cost of this coverage. The proposed coverage shall not take effect until this application has been accepted by the other underwriting companies, as applicable, and shall become effective only in accordance with the provisions of such agreements or group policies. I understand that I am not entitled to change my coverage elections during the plan year, unless I experience a special enrollment situation (i.e., marriage, divorce, birth, death, adoption, placement for adoption, or loss of other insurance coverage). I also understand that if I experience a qualifying event, I may elect to terminate coverage for myself and/or dependents by providing written notice to my employer within 31 days of the qualifying event.

I authorize EMI Health to share PHI concerning me and my family, including adult dependents, with any health care provider or HSA/HRA administrator providing benefits. I understand that any person who includes any false or misleading information on an application for an insurance policy may be subject to criminal and civil penalties.

Employee Signature | Date

4 EMPLOYER SIGN-OFF

Approved By

Approved On

I have reviewed the information provided above to confirm accuracy and eligibility. This form is approved for processing.

AMERICAN LEGACY STUCCO & STONE

HEALTH PLAN WAIVER

241

1 ACTIVE EMPLOYEE INFORMATION

First Name			Last Name		
Cell Phone			Email		
Address			City, State	Zip	
Position			Hire Date	Eligibile	
Social Sec			Birth Date	Sex	

2 WAIVER OF OFFERED HEALTH INSURANCE PLANS

ENROLL or WAIVE

I choose not to participate in the following group benefits that have been offered and waive such coverage(s).

Medical

English

3 CERTIFICAT

I understand that I may later apply for these benefits if I experience a special enrollment situation (i.e., marriage, divorce, birth, death, adoption, pl rance coverage), or during my employers next open enrollment

Spanish

Employee Signature Date

4 EMPLOYER SIGN-OFF

Approved By		I have reviewed the information provided above to confirm accuracy. This form is approved for processing.
Approved On		

INSURANCE
Legal Notices

Read If You'd Like — Ask If You Need

The next section includes a collection of required employmlent notices. We know it can feel like a lot of fine print, but these documents are provided to protect you and keep you informed of your rights and options. **You don't need to study every word — just know they're here for your reference.**

While we make every effort to translate our materials into Spanish, some of these legal notices are only available in English. If you ever have questions or want help making sense of any of it, your HR team is always happy to help. **You can reach us at HR@american-stucco.com.**

For future reference, these notices are posted and kept updated in our online Employee Portal with our other policies and important notices.

SUMMARY PLAN DESCRIPTION
OF THE

American Legacy Stucco and Stone, Inc
Health and Welfare Benefit Plan

Effective January 1, 2026

TABLE OF CONTENTS

INTRODUCTION

American Legacy Stucco and Stone, Inc (hereinafter the "Employer") maintains the American Legacy Stucco and Stone, Inc Health and Welfare Benefit Plan (the "Plan") for the exclusive benefit of Employees who meet the eligibility requirements. The Plan is a large, single plan that provides a variety of benefits. Those benefits are referred to herein as "Components." Some of the Components are subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and provisions of the Internal Revenue Code of 1986, as amended ("Code"). This Summary Plan Description ("SPD") describes the requirements imposed by ERISA and the Code, and describes the administrative framework for all of the benefits that are provided. This document and its Exhibits, including the certificates of coverage issued by the insurance companies and the summary plan descriptions issued by the third-party administrators and/or Plan Administrator, constitute the SPD for each of the Components to the extent required by ERISA § 102.

Important: This SPD is only a summary of the key parts of the Plan, and a brief description of your rights as a Participant of a Component benefit. Be sure to proceed through this SPD carefully, so that you can make informed decisions that are right for you.

The Plan provides benefits through the following Components, as described in Exhibit B:

American Legacy Stucco and Stone, Inc Medical Plan

Each of these Components is summarized in a certificate of coverage booklet issued by an insurance company or a summary plan description issued by the third party administrators and/or Plan Administrator. A copy of each certificate of coverage or summary plan description is available upon request. Contact your Plan Administrator. **This document plus the Exhibits and Attachments together are the SPD for the Plan. It is very important to check the Parts of Exhibit B relating to each Component Benefit.**

Important: Benefits under each Component are provided pursuant to an insurance contract and/or pursuant to a governing plan document adopted by the Employer. If the terms of this document conflict with the terms of such insurance contract or governing plan document, then the terms of the insurance contract or governing plan document will control, rather than this document, unless otherwise required by law.

I.
GENERAL INFORMATION ABOUT THE PLAN

I.1. What is the purpose of the Plan?

The purpose of the Plan is to provide certain Employees with an opportunity to receive certain benefits as part of an employee welfare benefit plan, as further described herein. You are being provided this document to give you an overview of the Plan and to address certain information that may not be addressed in the Exhibits.

I.2. When did the Plan take effect?

This Plan has been adopted effective January 1, 2026.

It operates on a "Plan Year" running from January 1 through December 31. It is important to note that some Components of the Plan may operate on a different Plan Year than the ERISA Wrap Plan Year identified above.

I.3. Who can participate in the Plan?

Each Employee of the Employer shall be eligible to participate in the Plan upon meeting the eligibility requirements (e.g., hourly work requirements, etc.) of any one of the applicable Components identified in Exhibit B. These employees are called "Eligible Employees." Those Eligible Employees who actually participate in one or more Components of the Plan are called "Participants." There are certain exceptions. They are described in the underlying Plan document. You will be notified if you fall within one of those exceptions.

"Employee" means a common-law employee of the Employer, except that the term "Employee" does not include any common-law employee who is a leased employee (including, but not limited to, an individual defined in Internal Revenue Code § 414(n)), or any common-law employee who is an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such person is on the Employer's W-2 payroll. The term "Employee" also does not include any individual who performs services for the Employer but who is paid by a temporary or other employment agency or any employee covered under a collective bargaining agreement unless the collective bargaining agreement so provides. The term "Employee" includes "former employees" for the limited purpose of allowing continued eligibility for benefits as provided hereunder after an employee ceases to be employed by the Employer.

To determine whether you are eligible to participate in a Component identified in Exhibit B, please read the eligibility information contained within the Exhibit for the applicable Component.

I.4. When do I become a Participant?

For newly Eligible Employees, participation may begin as described in each of the Components identified in Exhibit B. Participation dates may vary based upon the Component and classification of an Eligible Employee.

Special rules that limit entrance apply if you do not become a Participant in any of the Components identified in Exhibit B when first eligible. For some Components, you may become a Participant at the start of any subsequent Plan Year, subject to any applicable evidence of insurability requirements imposed by the Components. Other Components do not have regular entry dates. In addition, with certain Components, you may begin participation at other times under certain circumstances. For example, see

the description of HIPAA Special Enrollment that applies to the Component providing group health coverage described in Exhibit B.

I.5. Can others be covered through me?

Depending upon the terms and conditions of a particular Component, you may be able to have certain family members (e.g., child, spouse, etc.) covered through you. In order for other persons to be covered through you, you must be (and remain) a Participant in the Plan and under the particular Component(s).

I.6. What are the conditions of participation?

As a condition of participation and receipt of benefits under the Plan, you agree to:

(a) Observe all Plan rules and regulations;

(b) Consent to inquiries by the Plan with respect to any provider of services involved in a claim under the Plan;

(c) Submit to the Plan all notifications, reports, bills, and other information that the Plan may reasonably require;

(d) Agree to repay any overpayments or incorrect payments received through the Plan; and

(e) Agree to provide required proof or documentation regarding eligibility within thirty (30) days of the request.

Failure to do so may impact your ability to participate in the Plan (including the Components).

I.7. When does participation end?

Participation in the Plan ends when you are no longer covered under any of the Components, regardless of the reason. In general, participation in any of the Components identified in Exhibit B continues until you elect not to participate, you are no longer an Eligible Employee, the Component terminates, you fail to make contributions in a timely manner, or your participation is terminated for cause. In most cases, benefit coverage ends on the last day of the month in which such an event occurs. However, different Components may have different "last day of coverage" rules depending upon the type of benefit and the reason for the cessation of participation. Furthermore, if you fail to make contributions in a timely manner, coverage may end on the last day of the last month for which you made the full contribution and there are other situations (e.g., fraud) in which coverage may be terminated retroactively (i.e., rescinded) when allowed by applicable law.

With respect to others who are covered through you, their coverage typically ceases if your coverage ceases. In addition, there may be other reasons that their coverage may end independently of whether your coverage ends (e.g., cease to meet the definition of dependent child).

I.8. How do I enroll and make benefit elections?

The Employer, in its capacity as Plan Administrator, will provide you with the means necessary to enroll and make elections for the Components identified in Exhibit B, including information about the costs of the various Component benefits. For additional information regarding enrollment and benefit elections

for a Component identified in Exhibit B, please read the information contained within the Exhibit applicable to the particular Component(s).

I.9. Can I change my election in a Component of the Plan during the Plan Year?

Whether a change in coverage under a particular Component can occur during the Plan Year depends upon the terms and conditions (1) of the Component, and (2) to the extent you pay for any portion of the cost of coverage on a pre-tax basis, the Employer's cafeteria plan under Section 125 of the Code (reflected in a separate document).

Note: If you are interested in making a change in coverage under a Component of this Plan, it is very important to check the Exhibit B Part relating to that Component. And, if you pay your share of the cost of coverage through the Employer's cafeteria plan, you need to check that plan's terms and conditions regarding changes during the Plan Year.

I.10. Must I make contributions to receive coverage and, if so, who holds the contributions I pay for a Component benefit?

The Employer may require you to pay all or a portion of the cost of coverage under a Component. If so, the Employer will notify you of the applicable contribution rates. Your required contributions (if any) may be made on a pre-tax basis if allowed under the Employer's cafeteria plan. If pre-tax contributions cannot be made through the cafeteria plan, you must make after-tax contributions. Such contributions are generally due by the first day of each month unless the Employer has agreed to another payment schedule, as identified in Exhibit A. A contribution grace period will be provided if one is required under applicable law or one is needed to ensure an offer of coverage has been made in accordance with Treas. Reg. § 54.4980H-3(g).

Your contributions towards the cost of coverage are held in the Employer's general assets. There is no separate trust. The contributions are held as part of the Employer's general assets until they are used to provide coverage under a Component (e.g., forwarded to the insurance carrier, used to pay benefits, etc.).

I.11. What happens when there is an insurance company refund?

Any refund provided to the Employer by an insurance company that has issued an insurance contract for any Component provided under the Plan will be allocated in accordance with the then prevailing United States Department of Labor (DOL) guidance. As a Participant in the Plan, you may directly benefit from such a refund. The portion of the refund allocated to Participants will be (i) used solely for the benefit of the Participants participating in the Component with respect to which the refund was provided, and (ii) returned to such Participants in a manner allowed by applicable law (e.g., to provide a refund, a premium holiday, an increase in benefits, etc.), as determined by the Plan. The portion of the refund allocated to Participants will be returned to the Participants no later than three (3) months following the date on which the Employer receives such refund from the insurance company.

I.12. What are the tax consequences to me?

Just because benefits are provided by your Employer under this Plan does not necessarily mean they are provided on a tax favored basis to you. Depending upon a variety of factors (including the type of benefit, the amount of the benefit, characteristics of the Eligible Employees and Participants, characteristics of those covered through Participants (e.g., children, spouse, etc.), etc.), the value of the benefit may or may not result in taxable wages to you.

I.13. Will I have any administrative costs under the Plan?

No. The entire cost of administering the Plan is paid by the Employer.

I.14. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan (including each of the Components) indefinitely, the Employer has the right to amend or terminate the Plan in whole or in part at anytime. It is also possible that future changes in state or federal laws may require that the Plan be amended or terminated accordingly. You will be informed if changes are made to the Plan.

I.15. How are claims determined?

ERISA requires certain rules to be followed regarding the determination of claims for benefits (e.g., format, time frames, notifications, etc.). What rules apply in a particular situation depend upon a variety of factors (including the type of benefit, whether it is provided on an insured or self-insured basis, etc.). The underlying Plan document provides the overall structure for determining claims while many of the specifics of the particular Component are described in the Exhibit relating to that Component. It is intended that the claims procedures be in conformance with the applicable ERISA requirements.

Special note regarding the Medical Plan Component. With respect to the American Legacy Stucco and Stone, Inc Medical Plan Component of the Plan, the Patient Protection and Affordable Care Act ("PPACA") also requires certain rules to be followed. The specifics of these rules and their application to the Medical Plan Component of the Plan are described in the Plan document and also in **Exhibit B-1. Affordable Care Act Compliance Policy** and its attachments for that Component (and subsequent changes to that Exhibit and its attachments). It is intended that the claims procedures be in conformance with the applicable PPACA requirements.

I.16. Can I assign my right to benefits under the Plan?

In general, benefits payable under the Plan (including any Component) cannot be assigned. However, with respect to particular Components, you may have limited rights to assign benefits to providers of health care services.

II.
CONTINUATION COVERAGE

II.1. What are my continuation rights under COBRA?

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires most employers to offer Employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where health coverage under an employer sponsored group health plan(s) would otherwise end. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may have to pay all of the premium for the continuation coverage. Medical benefits shall be operated consistent with COBRA and pursuant to COBRA policies and procedures contained in a separate document, which is incorporated by reference into the Plan and this SPD and is available to you upon request, at no charge.

II.2. What are my continuation rights under USERRA?

If you are called to active duty in the uniformed services, you may elect to continue coverage for you and your eligible dependents under Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") for a period of up to 24 months. You and your eligible dependents qualify for this extension if you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States. This continuation right is similar to, and runs concurrent with, your continuation rights under COBRA (if any). The Medical benefits shall be operated consistent with USERRA and pursuant to USERRA policies and procedures contained in a separate document, which is incorporated by reference into the Plan and this SPD and is available to you upon request, at no charge.

II.3. What are my continuation and/or conversion rights for group health plan coverage under state law?

Some, but not all, states require continuation and/or conversion of group health insurance upon certain events. If provided under applicable state law, your continuation and/or conversion rights, and the rights of those who are covered through you, are described in the separate materials that have been provided to you either directly by the carrier (the insurance company) or by your Employer. If you have not been provided this information, you should contact the Employer.

III.
FAMILY AND MEDICAL LEAVE ACT OF 1993

III.1. Family and Medical Leave Act of 1993

The Family and Medical Leave Act of 1993 ("FMLA") imposes certain obligations on employers with fifty (50) or more Employees. In particular, the FMLA provides special protections for group health coverage. This Plan (including the Components) shall be administered in a manner consistent with the FMLA and the Employer's FMLA policy required thereunder which is incorporated by reference into the Plan and this SPD. If applicable to your situation, you will be provided with an explanation of your FMLA rights and responsibilities with respect to benefits under the Plan.

IV.
STATEMENT OF ERISA RIGHTS

As a Participant in this Plan (including any Components), you are entitled to certain rights and protections under ERISA.

Receive Information About Your Plans and Benefits. ERISA provides that all Participants shall be entitled to:

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

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

(c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this Summary Annual Report ("SAR").

COBRA Rights. As a Participant in the Plan, you are entitled to continue health coverage for yourself, your spouse or your dependents if there is a loss in coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Very Important: Exhaustion of Administrative Procedures Required; Statute of Limitations. The right to maintain a court action is subject to the Plan's requirements that administrative procedures be completed first. This is called exhaustion of administrative remedies. **Failure to exhaust administrative procedures may preclude you from bringing an action in court**. Furthermore, if you intend to initiate legal action related to the Plan, including legal action for benefits under the Plan pursuant to Section 502(a) of ERISA, you must do so within two (2) years after receipt of a notification of an adverse benefit determination at the final level of appeal provided under the Plan. If, due to special circumstances, you were not required to exhaust your administrative remedies, legal action must be brought within two (2) years of the date the relevant claim for benefits was submitted to the Plan. You may not bring legal action after the expiration of the applicable limitations period. These deadlines for bringing a legal action apply unless a different time period is provided in Part of Exhibit B applicable to the Component with respect to which the action is being brought.

Assistance with Your Questions.

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

EXHIBIT A. Employer and Plan Information

PART I. Employer Details

Employer and Plan Sponsor:	American Legacy Stucco and Stone, Inc 12455 N 92nd Drive Suite 103 Peoria, AZ 85381 Phone: 602-799-0513 Email: HR@american-stucco.com
Employer Business Type:	Corporation
Employer Identification Number (EIN):	27-3892368
State of Incorporation:	Arizona
Employer subject to ERISA?	Yes
Commonly Controlled Entities:	N/A

PART II. General Plan Information

Name of Plan:	American Legacy Stucco and Stone, Inc Health and Welfare Benefit Plan
Plan Year:	January 1 through December 31
Plan Number:	501
Effective Date of Plan:	January 1, 2026
Type of Plan:	The Plan provides comprehensive Medical and benefits and is considered a "Health and Welfare Benefit Plan" under ERISA.
Plan Administrator:	American Legacy Stucco and Stone, Inc 12455 N 92nd Drive Suite 103 Peoria, AZ 85381 Phone: 602-799-0513 Email: HR@american-stucco.com

Agent for Service of Legal Process:	American Legacy Stucco and Stone, Inc 12455 N 92nd Drive Suite 103 Peoria, AZ 85381 Phone: 602-799-0513 Email: HR@american-stucco.com Legal process may also be served on the Plan Administrator.
Named Fiduciary:	American Legacy Stucco and Stone, Inc 12455 N 92nd Drive Suite 103 Peoria, AZ 85381 Phone: 602-799-0513 Email: HR@american-stucco.com

PART III. Additional Plan Details

COBRA Administrator:	American Legacy Stucco and Stone, Inc 12455 N 92nd Drive Suite 103 Peoria, AZ 85381 Phone: 602-799-0513 Email: HR@american-stucco.com
Pay Period and Benefit Payment Frequency:	Pay Period Frequency: Weekly Contributions/payments for benefits are taken at the same time as the pay period.

EXHIBIT B. Component Benefit Plans

PART I. Carrier/Administrator Details

Benefit Type	Policy Name	Insurer/Administrator	Policy Number/ Group ID	Claims Administrator	Funding	Policy/Plan Year
Medical	EMI BCBS $6,500 / $8,500	EMI Health 5101 S Commerce Dr, Murray, UT, 84107 Phone: 801-270-2967	7988	Insurer/Carrier	Self Insured	01/01/2026-12/31/2026
	MEC Enhanced	EMI Health 5101 S Commerce Dr, Murray, UT, 84107 Phone: 801-270-2967	7988	Insurer/Carrier	Self Insured	01/01/2026-12/31/2026
	MEC Basic	EMI Health 5101 S Commerce Dr, Murray, UT, 84107 Phone: 801-270-2967	7988	Insurer/Carrier	Self Insured	01/01/2026-12/31/2026

PART II. Specific Plan/Policy Information

Benefit Type	Policy/Plan Name	Eligibility	Waiting Period	Coverage Ends	Spouse/Dependent Coverage (incl. Domestic Partners)	Employer Contribution	Premium Payment	COBRA	ERISA
Medical	EMI BCBS $6,500 / $8,500	All Employees	First of the month following 60 days after date of hire	Last day of the month in which eligibility ends	Legal Spouse and Dependent Child(ren) No Domestic Partner Coverage	Yes - Portion of premium paid by Employer	Pre-tax	Yes	Yes
	MEC Enhanced	All Employees	First of the month following 60 days after date of hire	Last day of the month in which eligibility ends	Legal Spouse and Dependent Child(ren) No Domestic Partner Coverage	Yes - Portion of premium paid by Employer	Pre-tax	Yes	Yes
	MEC Basic	All Employees	First of the month following 60 days after date of hire	Last day of the month in which eligibility ends	Legal Spouse and Dependent Child(ren) No Domestic Partner Coverage	Yes - Portion of premium paid by Employer	Pre-tax	Yes	Yes

Exhibit B-1. Affordable Care Act Compliance Policy

American Legacy Stucco and Stone, Inc Health and Welfare Benefit Plan

Provisions under the Affordable Care Act

Purpose. The Purpose of this Affordable Care Act Compliance Policy ("ACA Compliance Policy") is to describe the methods established by the Employer, American Legacy Stucco and Stone, Inc to remain compliant with the Affordable Care Act regulations regarding eligibility for health benefits.

The Patient Protection and Affordable Care Act ("PPACA" or "ACA") imposed rules for Applicable Large Employers ("ALE") that include, but are not limited to, definition and calculation of hours of service, classification of employees, eligibility determinations for health plans, and providing standards for plan affordability. The method(s) outlined in this policy apply specifically to benefit plans offering medical coverage.

Special Definitions.

(a) **Applicable Large Employer** means an employer that employed an average of at least 50 Full-Time Employees (including Non-Full-Time Employees ("Full-Time Equivalent" or "FTE") averaging at least 30 hours per week) during the preceding calendar year.

(b) **Employee** has the meaning set forth in the Plan.

(c) **Hour of Service** means (1) each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the company; (2) each hour for which an Employee is paid, or entitled to payment, by the Employer for a period of time during which no duties are performed (e.g., paid vacation, holiday, illness, disability, layoff, jury duty, military leave, paid leave of absence); and (3) each hour of unpaid leave that is subject to FMLA, USERRA, or on account of jury duty.

(d) **New Employee** means an Employee who was rehired after expiration of the parity period established for the plan.

(e) **Ongoing Employee** means an Employee who was rehired within the parity period established for the Plan.

(f) **Patient Protection and Affordable Care Act ("PPACA" or "ACA")** means the comprehensive health care reform law enacted on March 23, 2010, that provides numerous rights and protections making health coverage more accessible and affordable and imposes requirements on applicable Employers to offer affordable health coverage to Full Time Employees.

(g) **Special Unpaid Leave** means unpaid leave subject to the Family and Medical Leave Act OF 1993 (FMLA) or to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) or on account of jury duty.

(h) **Waiting Period** – the period of time that must pass before coverage for an Employee (or their dependent who is otherwise eligible to enroll in the Plan) becomes effective. The ACA prohibits waiting periods for New Employees for group health plan benefits that exceed 90 days.

Rehired Employees. If an Employee has a period of 13 weeks or longer (26 weeks if the Employer is an academic institution) during which the Employee was credited zero Hours of Service, then the Employee may be treated as an Employee whose employment was terminated and who is a New Employee, not an Ongoing Employee, upon resuming services for the Employer. The Employee will need to complete the applicable waiting period before becoming eligible for benefits again.

If an Employee has a period of less than 13 weeks (26 weeks if the Employer is an academic institution) during which the Employee was credited zero Hours of Service, then the Employee will be treated as an ongoing Employee. The Employer must offer health plan coverage as of the first day that the rehired Employee is credited with an Hour of Service, on the first day of the calendar month following the day the Employee first received credit for an Hour of Service or, if later, as soon as administratively feasible.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please call 1-800-662-5851. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-662-5851 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For participating providers: **$0** For non-participating providers: **$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out–of–pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.emihealth.com or call **1-800-662-5851** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered	Not covered	——————none——————
	Specialist visit	Not covered	Not covered	——————none——————
	Preventive care/screening/immunization	No charge	Not covered	Coverage is limited to one visit per Year for some services. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.emihealth.com.	Generic drugs	ACA Preventive Care Mandates - No charge All Others - Not covered	Not covered	Up to a 30-day supply (retail prescription) per copay; up to a 90-day supply (mail order prescription) per copay
	Preferred brand drugs	ACA Preventive Care Mandates - No charge All Others - Not covered	Not covered	Up to a 30-day supply (retail prescription) per copay; up to a 90-day supply (mail order prescription) per copay
	Non-preferred brand drugs	ACA Preventive Care Mandates - No charge All Others - Not covered	Not covered	Up to a 30-day supply (retail prescription) per copay; up to a 90-day supply (mail order prescription) per copay
	Specialty drugs	Not covered	Not covered	——————N/A——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	N/A
	Physician/surgeon fees	Not covered	Not covered	N/A
If you need immediate medical attention	Emergency room care	Not covered	Not covered	N/A
	Emergency medical transportation	Not covered	Not covered	N/A
	Urgent care	Not covered	Not covered	N/A
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	N/A
	Physician/surgeon fee	Not covered	Not covered	N/A
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	N/A
	Inpatient services	Not covered	Not covered	N/A
If you are pregnant	Office visits	Not covered	Not covered	Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	N/A
	Rehabilitation services	Not covered	Not covered	N/A
	Habilitation services	Not covered	Not covered	N/A
	Skilled nursing care	Not covered	Not covered	N/A
	Durable medical equipment	Not covered	Not covered	N/A
	Hospice services	Not covered	Not covered	N/A

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Routine: No charge	Routine: Not covered	Limited to one preventive visit per Year.
		Non-routine: Not covered	Non-routine: Not covered	——————N/A——————
	Children's glasses	Not covered	Not covered	——————N/A——————
	Children's dental check-up	Not covered	Not covered	——————N/A——————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-662-5851, your state insurance department, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov, or for plans subect to ERISA: the Department of Labor's Employee Benefits Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: EMI Health at 5101 South Commerce Drive, Murray Utah 84107, by phone at 801-662-5851 or toll free at 1-800-662-5851. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-44-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **No.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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About these Coverage Examples:

This is not a cost estimator. Treaments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,600
The total Peg would pay is	**$12,600**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$5,400
The total Joe would pay is	**$5,400**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,800
The total Mia would pay is	**$2,800**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please call 1-800-662-5851. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-662-5851 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For participating providers: **$0** For non-participating providers: **$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out–of–pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.emihealth.com or call **1-800-662-5851** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/ visit for the first 3 visits per year, then not covered	Not covered	Coverage is limited to three visits per Year
	Specialist visit	$50 copay/ visit for the first 3 visits per year, then not covered	Not covered	Coverage is limited to three visits per Year
	Preventive care/screening/immunization	No charge	Not covered	Coverage is limited to one visit per Year for some services. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay/ office or outpatient visit for the first 3 visits per year, then not covered Inpatient not covered	Not covered	Coverage is limited to three visits per Year
	Imaging (CT/PET scans, MRIs)	$250 copay for the first visit per year, then not covered	Not covered	Coverage is limited to one visit per Year. Requires preauthorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.emihealth.com.	Generic drugs	ACA Preventive Care Mandates - No charge All Others - 10% coinsurance	Not covered	Up to a 30-day supply (retail prescription) per copay; up to a 90-day supply (mail order prescription) per copay
	Preferred brand drugs	ACA Preventive Care Mandates - No charge All Others - 50% coinsurance	Not covered	Up to a 30-day supply (retail prescription) per copay; up to a 90-day supply (mail order prescription) per copay
	Non-preferred brand drugs	ACA Preventive Care Mandates - No charge All Others - Not covered	Not covered	Up to a 30-day supply (retail prescription) per copay; up to a 90-day supply (mail order prescription) per copay
	Specialty drugs	Not covered	Not covered	——————N/A——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	——————N/A——————
	Physician/surgeon fees	Not covered	Not covered	——————N/A——————
If you need immediate medical attention	Emergency room care	Not covered	Not covered	——————N/A——————
	Emergency medical transportation	Not covered	Not covered	——————N/A——————
	Urgent care	$50 copay/ visit for the first 3 visits per year, then not covered	Not covered	Coverage is limited to three visits per Year
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	——————N/A——————
	Physician/surgeon fee	Not covered	Not covered	——————N/A——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	——————N/A——————
	Inpatient services	Not covered	Not covered	——————N/A——————
If you are pregnant	Office visits	Not covered	Not covered	Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	——————N/A——————
	Rehabilitation services	Not covered	Not covered	——————N/A——————
	Habilitation services	Not covered	Not covered	——————N/A——————
	Skilled nursing care	Not covered	Not covered	——————N/A——————
	Durable medical equipment	Not covered	Not covered	——————N/A——————
	Hospice services	Not covered	Not covered	——————N/A——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Routine: No charge	Routine: Not covered	Limited to one preventive visit per Year.
		Non-routine: Not covered	Non-routine: Not covered	N/A
	Children's glasses	Not covered	Not covered	N/A
	Children's dental check-up	Not covered	Not covered	N/A

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-662-5851, your state insurance department, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov, or for plans subect to ERISA: the Department of Labor's Employee Benefits Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: EMI Health at 5101 South Commerce Drive, Murray Utah 84107, by phone at 801-662-5851 or toll free at 1-800-662-5851. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-44-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **No.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About these Coverage Examples:

This is not a cost estimator. Treaments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:

Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$11,300
The total Peg would pay is	**$11,500**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:

Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,800**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,600
The total Mia would pay is	**$2,700**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please call 1-800-662-5851. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-662-5851 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For participating providers: **$6,500 person / $13,000 family for calendar year** For non-participating providers: **$13,000 person / $26,000 family for calendar year**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, prescription drugs, and office visits are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	For participating providers: **$8,500 person / $17,000 family** For non-participating providers: **$17,000 person / $34,000 family**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, Additional Benefits, certain specialty pharmacy drugs, and penalties for failure to obtain preauthorization for services	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.emihealth.com or call **1-800-662-5851** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Tier 1- $10, Tier 2- $40 copay/ visit; deductible does not apply	50% coinsurance	——————none——————
	Specialist visit	Tier 1- $20, Tier 2- $75 copay/ visit; deductible does not apply	50% coinsurance	——————none——————
	Preventive care/screening/immunization	No charge; deductible does not apply	Not covered	Coverage is limited to one visit per Year for some services. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge/ office visit; deductible does not apply No charge/ outpatient visit; deductible does not apply No charge after deductible/ inpatient services	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	No charge after deductible	50% coinsurance	Requires preauthorization

* For more information about limitations and exceptions, see the plan or policy document at www.emihealth.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.emihealth.com.	Generic drugs	$20 copay/ prescription Retail $50 copay/ prescription Mail Order	Not covered	Up to a 30-day supply (retail prescription) per copay; up to a 90-day supply (mail order prescription) per copay
	Preferred brand drugs	$75 copay/ prescription Retail $190 copay/ prescription Mail Order	Not covered	Up to a 30-day supply (retail prescription) per copay; up to a 90-day supply (mail order prescription) per copay
	Non-preferred brand drugs	$150 copay/ prescription Retail $375 copay/ prescription Mail Order	Not covered	Up to a 30-day supply (retail prescription) per copay; up to a 90-day supply (mail order prescription) per copay
	Specialty drugs	Generic - 25% coinsurance ($150 maximum copay/ prescription) Preferred - 25% coinsurance ($250 maximum copay/ prescription) Non-Preferred - 30% coinsurance ($500 maximum copay/ prescription)	Not covered	Covers up to a 90-day supply (mail order prescription) per copay. The cost of certain drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards your out-of-pocket limit. See http://emihealth.com/pdf/saveon.pdf for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	50% coinsurance	Some procedures require preauthorization
	Physician/surgeon fees	No charge after deductible	50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	No charge after deductible	No charge after deductible	——————none——————
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	$100 copay/ visit; deductible does not apply	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	50% coinsurance	Requires preauthorization
	Physician/surgeon fee	No charge after deductible	50% coinsurance	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Tier 1- $10, Tier 2- $40 copay/ office visit; deductible does not apply and no charge after deductible other outpatient services	50% coinsurance	Medications for substance abuse not covered
	Inpatient services	No charge after deductible	50% coinsurance	Requires preauthorization
If you are pregnant	Office visits	No charge after deductible	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge after deductible	50% coinsurance	
	Childbirth/delivery facility services	No charge after deductible	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge after deductible	50% coinsurance	——————none——————
	Rehabilitation services	Tier 1- $10, Tier 2- $40 copay/ office and outpatient visit; deductible does not apply and no charge after deductible other inpatient services	50% coinsurance	Coverage limited to 20 outpatient visits per injury/illness and 40 inpatient days per Year.
	Habilitation services	Not covered	Not covered	——————N/A——————
	Skilled nursing care	No charge after deductible	50% coinsurance	Coverage limited to 30 days per Year. Admission must be within 5 days of a discharge from Hospital Confinement.
	Durable medical equipment	No charge after deductible	50% coinsurance	Requires preauthorization
	Hospice services	No charge after deductible	50% coinsurance	——————none——————
If your child needs dental or eye care	Children's eye exam	Routine: No charge; deductible does not apply	Routine: Not covered	Limited to one preventive visit per Year.
		Non-routine: $75 copay/ visit; deductible does not apply	Non-routine: 50% coinsurance	——————none——————
	Children's glasses	Not covered	Not covered	——————N/A——————
	Children's dental check-up	Not covered	Not covered	——————N/A——————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Habilitation services	• Private-duty nursing
• Bariatric surgery	• Infertility treatment	• Routine foot care
• Cosmetic surgery	• Long-term care	• Weight loss programs
• Dental care (Adult)		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care (20 visits per year)	• Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult) (1 visit per year)
• Hearing aids ($2,500 per year)		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-662-5851, your state insurance department, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov, or for plans subect to ERISA: the Department of Labor's Employee Benefits Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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Does this plan provide Minimum Essential Coverage? **Yes.**

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Does this plan meet the Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$6,500
Specialist copayment	$75
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,500
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,570**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$6,500
Specialist copayment	$75
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	**$2,270**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$6,500
Specialist copayment	$75
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,200
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

HIPAA Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment **within 30 days** after your other coverage ends.

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, provided that you request enrollment **within 30 days** after the marriage, birth, adoption, or placement for adoption.

If you would like more information, please reference your Summary Plan Description or contact Human Resources at HR@american-stucco.com.

You may also be able to enroll yourself and your dependents if you or your dependents lose eligibility for Medicaid or a State Children's Health Insurance Program (CHIP), or if you or your dependents become eligible for premium assistance under Medicaid or CHIP. You must request enrollment within 60 days of the loss of Medicaid/CHIP coverage or within 60 days of becoming eligible for premium assistance.

HIPAA Privacy Notices

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You have some choices in the way that we use & share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at HR@american-stucco.com.
- You can file a complaint with the U.S. Department of Health and Human Services Office, for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C., 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. If you

- have a clear preference for how we share your information in the situations described below, talk
- to us. Tell us what you want us to do, and we will follow your instructions.
- In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your
- care
- Share information in a disaster relief situation
    - If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.
    - Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
    - Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.
    - Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.
    - Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We may share health information about you for situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

AZ HIPAA Privacy Notices

This notice describes how your personal and medical information that you provide us may be used and disclosed and how you can get access to this information, please review it carefully.

Confidentiality Practices

The Arizona Department of Economic Security (DES) is committed to protecting your Personal Identifying Information (PII) and Protected Health Information (PHI). This notice explains how DES will use, share, and protect your PII and PHI. It also explains your rights to privacy of your PII and PHI as required by law. DES can change the terms of this notice, and the changes will apply to all information we have about you. The revised notice will be posted to our web site and will be provided to you on request.

Collection, Storage, and Disposal of PII and PHI

The DES and its programs will identify and collect the minimum PII and PHI data elements that are relevant and necessary to conduct the business functions it is legally authorized to perform. It will review the use of the PII and PHI data elements annually to ensure that only the necessary data is collected and stored for business purposes. Your PII and PHI will be stored in our computer systems and paper files, if necessary, according to State and Federal retention laws. Access to these computer systems is restricted based on a person's job functions and role within the organization.

Uses, Sharing, and Protection of PII and PHI

The law only allows our staff to use your PII and PHI when doing their jobs or to share your information when it is necessary to run the program. When PII and PHI is shared with other agencies or organizations, DES requires them to keep your PII and PHI confidential. Your PHI will be shared to approve or deny treatment, and to determine if you are getting the right medical treatment. For example, doctors and nurses employed by the programs may review the treatment plan created for you by your health care provider to make sure the care you receive is medically necessary.

The Program Will Use and Share Your PHI Without Authorization to:

- Make payments to your health care providers for medical services provided to you.
- Coordinate payment for your care between the program, other health plans, and other insurance companies that may be responsible for the cost of your care.
- Coordinate your care between the program, other health plans, and health care providers to improve the quality of your health care.
- Evaluate the performance of your health care provider. For example, the program contracts with consultants to review hospital and other facilities' medical records to check on the quality of care you received.
- Release information to its attorneys, accountants, and consultants so that the program is run efficiently and to detect and prosecute program fraud and abuse.
- Send you helpful information such as program benefit updates, free medical exams, and consumer protection information.
- Share information with other government agencies or organizations that provide benefits or services when the information is necessary in order for you to receive those benefits or services.

The Program May Disclose Your PHI Without Authorization:

- To public health agencies for activities such as disease control and prevention, problems with medical products or medications.
- If you are the victim of abuse, neglect or domestic violence.
- To health oversight agencies responsible for the Medicaid Program such as the U.S. Department of Health and Human Services and its Office of Civil Rights.
- In court cases or judicial and administrative hearings when required by law to run the program.
- To coroners, medical examiners, funeral directors so they can carry out their jobs as required by law.
- To organizations involved with organ donation and transplantation, communicable disease
- registries and cancer registries.
- To entities authorized to conduct a research project.
- To prevent a serious threat to a person's or the public's health and safety.
- To the military if you are or have been a member of the armed services.

- To a correctional facility or law enforcement officials to maintain the health, safety, and
- security of the corrections systems, if you are held in custody.
- To workers' compensation programs that provide benefits for work-related injuries or illness
- without regard to fault.
- To law enforcement or national security and intelligence agencies, and to protect the
- President and others as required by law.

All other uses and disclosures will be made only with your written authorization. These may include:

- Most uses and disclosures of your psychotherapy notes will require your authorization.
- Any use or disclosure for marketing purposes will require your authorization.
- Any use or disclosure that would constitute a sale of your information will require your authorization.

Your Other Rights Concerning Your PII and PHI Includes the Right to:

- See and get copies of your records. You may be charged a fee for the cost of copying your records.
- Request to have your records amended or corrected if you think there is a mistake. You must provide a reason for your request.
- Receive a list of disclosures. List will not include the time that information was disclosed for treatment, payment or health care operations covered under the law. The list will not include information provided to you or your family directly, or information that was sent with your authorization.
- Further restrict uses and disclosures of your PII and PHI. You must tell DES what information you want to limit and to whom you want the limits to apply. DES is not required to agree to the restriction.
- Cancel authorizations previously provided by you to DES. This cancellation, however, will not affect any information that has already been shared.
- Receive a written notification in the event of a breach of your protected information.
- Choose how the program communicates with you in a certain way or at a certain place.

- Opt out of receiving fundraising communications.
- File a complaint if you do not agree with how DES has used or disclosed information about you.
- Receive a paper copy of this notice at any time.

ANY REQUEST YOU MAKE TO DES MUST BE IN WRITING

How to Contact DES Regarding Your Privacy Rights:

- Mail all written forms, requests and correspondence to:
    - Your local DES office

The Privacy Officer may deny your request to look at, copy or change your records. If DES denies your request, DES will send you a letter that tells you why your request is being denied and if you can request a review of that denial.

To File a Complaint

- You may file a complaint with DES or the U.S. Department of Health and Human Services-Office of Civil Rights:
    - (You will not be retaliated against for filing a complaint)
    - Send correspondence to:
        - Your local Department of Security
    - OR
        - For HIPAA Complaints Involving PHI
            - Department of Health and Human Services

              200 Independence Avenue, SW
              HHH Building, Room 509F
              Washington, D.C. 20201
        - For Privacy Complaints Involving PHI
            - HHS Privacy Act Officer

              200 Independence Avenue, SW
              HHH Building - Suite 729H
              Washington, D.C. 20201

For More Information

If you have any questions about this notice or need more information, please contact the DES Privacy Officer. DES may change its Notice of Privacy Practices. Any changes will apply to information DES already has, as well as any information DES may get in the future. A copy of any new notice will be posted at the DES HIPAA Administration Office as well as its website. You may ask for a copy of the notice at any time, or get it on-line at http://des,az.gov/

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."

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; 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 by email at HR@american-stucco.com within 60 days after the qualifying event occurs.**

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.

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?

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 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: 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

American Legacy Stucco & Stone, LLC.
12455 N 92nd Dr, Suite 102, Peoria, AZ 85381
HR@american-stucco.com; 602-799-0513

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.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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% 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?

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.

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:	4. Employer Identification Number (EIN):
American Legacy Stucco and Stone, Inc.	27-3892368
5. Employer Address	**6. Employer Phone Number**
12455 N 92nd Drive, Suite 103	607-799-0513
7. City	**8. State**	**9. ZIP Code**
Peoria	AZ	85381
10. Who can we contact about employee health coverage at this job?	
HR Department	
11. Phone Number (if different from above)	**12. Email Address**
	HR@american-stucco.com

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

- As your employer, we offer a health plan to:
  - [X] All employees. Eligible employees are:

    All regular full-time employees working 30 or more hours are eligible for benefits on the first day of the month after 60 days of employment. Must not be on leave of absence at time of effective date in order to sign up for benefits.
  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [X] We do offer coverage. Eligible dependents are:

    Legal spouse, domestic partner, biological child, stepchild, legally adopted child from which the employee is a legal guardian up to their 26th birthday.
  - [ ] We do not offer coverage to dependents.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Your Prescription Drug Plan and Medicare Part D

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with American Legacy Stucco and Stone, Inc. 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.

1. **American Legacy Stucco and Stone, Inc. offers multiple plans** and has determined that prescription drug coverage for the:
    - **EMI BCBS $6,500/$8,500 Plan IS considered Creditable Coverage**
        - The EMI BCBS $6,500/$8,500 Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

- **MEC Basic and MEC Enhanced health plans are NOT considered Creditable Coverage.**
  - The MEC and MEC Enhanced plans are, 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 MEC and MEC Enhanced plans. 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.
  - You can keep your current coverage from MEC and MEC Enhanced. 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.

For more information contact us at HR@american-stucco.com

Your Prescription Drug Plan and Medicare Part D FAQ's & More Information

When Can You Join a Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, or if you decide to drop your current NON-creditable coverage, 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 coverage will not be affected. Members can keep this coverage if they elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back during future open enrollment periods.

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 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. 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 changes. You may also 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).

Keep this Creditable Coverage notice. If you decide to join one of 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).

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Women's Health & Cancer Rights Act (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information, please reference your Summary Plan Description or contact Human Resources at HR@american-stucco.com.

Newborn's and Mother's Health Protection Act (NMHPA)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section.

However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

In addition, plans and issuers may not:

- Require that a provider obtain authorization from the plan or issuer for prescribing a length of stay of up to 48 hours (for vaginal delivery) or 96 hours (for cesarean section).

If you would like more information, please reference your Summary Plan Description or contact Human Resources at HR@american-stucco.com.

Mental Health Parity and Addiction Equity Act (MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that the financial requirements (such as copayments, deductibles, and coinsurance) and treatment limitations (such as number of visits or days of coverage) that apply to mental health or substance use disorder (MH/SUD) benefits cannot be more restrictive than those that apply to medical and surgical benefits under the plan.

In addition, non-quantitative treatment limits (such as prior authorization, medical management standards, or provider network admission criteria) for MH/SUD benefits must be comparable to, and applied no more stringently than, those applied to medical and surgical benefits.

You may request, at no charge, information about the criteria for medical necessity determinations with respect to MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply non-quantitative treatment limits. You may also request the reason for any denial of reimbursement or payment for MH/SUD services.

If you would like more information, please reference your Summary Plan Description or contact Human Resources at HR@american-stucco.com.

RETIREMENT

Legal Notices

Read If You'd Like — Ask If You Need

The next section includes a collection of required employmlent notices. We know it can feel like a lot of fine print, but these documents are provided to protect you and keep you informed of your rights and options. **You don't need to study every word — just know they're here for your reference.**

While we make every effort to translate our materials into Spanish, some of these legal notices are only available in English. If you ever have questions or want help making sense of any of it, your HR team is always happy to help. **You can reach us at HR@american-stucco.com.**

For future reference, these notices are posted and kept updated in our online Employee Portal with our other policies and important notices.

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AMERICAN LEGACY STUCCO & STONE, INC. DEFINED CONTRIBUTION PLAN

SUMMARY PLAN DESCRIPTION

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AMERICAN LEGACY STUCCO & STONE, INC. DEFINED CONTRIBUTION PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION TO YOUR PLAN

What kind of Plan is this?

American Legacy Stucco & Stone, Inc. Defined Contribution Plan ("Plan") has been adopted to provide you with additional income for retirement. This Plan is a type of qualified retirement plan commonly referred to as a profit sharing Plan. Generally you are not taxed on the amounts we contribute to the Plan on your behalf until you withdraw these amounts from the Plan.

What information does this Summary provide?

This Summary Plan Description ("SPD") contains information regarding when you may become eligible to participate in the Plan, your Plan benefits, your distribution options, and many other features of the Plan. You should take the time to read this SPD to get a better understanding of your rights and obligations under the Plan.

In this Summary, your Employer has addressed the most common questions you may have regarding the Plan. If this SPD does not answer all of your questions, please contact the Administrator or other Plan representative. The Administrator is responsible for responding to questions and making determinations related to the administration, interpretation, and application of the Plan. The name and address of the Administrator can be found at the end of this SPD in the Article entitled "General Information About the Plan."

This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language and is designed to comply with applicable legal requirements. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

The Plan and your rights under the Plan are subject to federal laws, such as the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code, as well as some state laws. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or Department of Labor (DOL). Your Employer may also amend or terminate this Plan. Your Employer will notify you if the provisions of the Plan that are described in this SPD change.

Types of contributions. The following types of contributions may be made under this Plan:

- Employer profit sharing contributions

ARTICLE I
PARTICIPATION IN THE PLAN

How do I participate in the Plan?

Provided you are not an Excluded Employee, you may become a "Participant" in the Plan once you have satisfied the eligibility requirements and reached your "Entry Date." The following describes the eligibility requirements and Entry Dates that apply. You should contact the Administrator if you have questions about the timing of your Plan participation.

Excluded Employees. If you are a member of a class of employees identified below, you are an Excluded Employee and you are not entitled to participate in the Plan. The Excluded Employees are:

- union employees whose employment is governed by a collective bargaining agreement under which retirement benefits were the subject of good faith bargaining, unless the collective bargaining agreement requires the employee to be included within the Plan
- certain nonresident aliens who have no earned income from sources within the United States

Eligibility conditions. You will be eligible to participate in the Plan when you have satisfied the following eligibility condition(s). However, you will actually become a Participant in the Plan once you reach the Entry Date as described below.

- completion of one (1) Year of Service.

Entry Date. Your Entry Date will be the first day of the Plan Year or the first day of the seventh month of the Plan Year coinciding with or next following the date you satisfy the eligibility requirements.

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How is my service determined for purposes of Plan eligibility?

Year of Service. You will be credited with a Year of Service at the end of the twelve month period beginning on your date of hire if you have been credited with at least 1,000 Hours of Service during such period. If you have not been credited with 1,000 Hours of Service by the end of such period, you will have completed a Year of Service at the end of any following Plan Year during which you were credited with 1,000 Hours of Service.

Hour of Service-employees for whom hourly records are kept. You will be credited with your actual Hours of Service for:

(a) each hour for which you are directly or indirectly compensated by the Employer for the performance of duties during the Plan Year;

(b) each hour for which you are directly or indirectly compensated by the Employer for reasons other than the performance of duties (such as vacation, holidays, sickness, disability, lay-off, military duty, jury duty or leave of absence during the Plan Year); and

(c) each hour for back pay awarded or agreed to by the Employer.

You will not be credited for the same Hours of Service both under (a) or (b), as the case may be, and under (c).

Hour of Service employees for whom hourly records are not kept. The Plan does not credit you with your actual Hours of Service. Instead the Plan uses an "equivalency" method. Under this method you will be credited with 190 Hours of Service for each month during the year in which you would otherwise be credited with at least one Hour of Service.

What service is counted for purposes of Plan eligibility?

Service with the Employer. In determining whether you satisfy the minimum service requirements to participate under the Plan, all service you perform for the Employer will generally be counted. However, there are some exceptions to this general rule.

Break in Service rules. If you terminate employment and are rehired, you may lose credit for prior service under the Plan's Break in Service rules.

For eligibility purposes, you will have a 1-Year Break in Service if you complete less than 501 Hours of Service during the computation period used to determine whether you have a Year of Service. However, if you are absent from work for certain leaves of absence such as a maternity or paternity leave, you may be credited with enough Hours of Service to prevent a Break in Service.

Five-year eligibility Break in Service rule. The five-year Break in Service rule applies only to employees who had no vested interest in the Plan when employment had terminated. If you were not vested in any amounts when you terminated employment and you have five 1-Year Breaks in Service (as defined above), all the service you earned before the 5-year period no longer counts for eligibility purposes. Thus, if you were to return to employment after incurring five 1-Year Breaks in Service, you would have to resatisfy any minimum service requirements under the Plan.

Military service. If you are a veteran and are reemployed under the Uniformed Services Employment and Reemployment Rights Act of 1994, your qualified military service may be considered service with the Employer. If you may be affected by this law, ask the Administrator for further details.

What happens if I'm a Participant, terminate employment and then I'm rehired?

If you are no longer a Participant because you terminated employment, and you are rehired, then you will be able to participate in the Plan on your date of rehire provided your prior service had not been disregarded under the Break in Service rules and you are otherwise eligible to participate in the Plan.

ARTICLE II
EMPLOYER CONTRIBUTIONS

This Article describes Employer contributions that may be made to the Plan and how your share of the contribution is determined.

What is the Employer profit sharing contribution and how is it allocated?

Profit sharing contribution. Each year, your Employer may make a discretionary profit sharing contribution to your account.

Allocation conditions. In order to share in the profit sharing contribution for a Plan Year, you must satisfy the following conditions:

- If you are employed on the last day of the Plan Year, you will share regardless of the amount of service you completed during the Plan Year.

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- If you terminate employment (not employed on the last day of the Plan Year), you will only share if you are credited with at least 501 Hours of Service during the Plan Year.

How is my service determined for allocation purposes?

Hour of Service-employees for whom hourly records are kept. You will be credited with your actual Hours of Service for:

(a) each hour for which you are directly or indirectly compensated by the Employer for the performance of duties during the Plan Year;

(b) each hour for which you are directly or indirectly compensated by the Employer for reasons other than the performance of duties (such as vacation, holidays, sickness, disability, lay-off, military duty, jury duty or leave of absence during the Plan Year); and

(c) each hour for back pay awarded or agreed to by the Employer.

You will not be credited for the same Hours of Service both under (a) or (b), as the case may be, and under (c).

Hour of Service-employees for whom hourly records are not kept. The Plan does not credit you with your actual Hours of Service. Instead the Plan uses an "equivalency" method. Under this method you will be credited with 190 Hours of Service for each month during the year in which you would otherwise be credited with at least one Hour of Service.

What are forfeitures and how are they allocated?

Definition of forfeitures. In order to reward employees who remain employed with the Employer for a long period of time, the law permits a "vesting schedule" to be applied to certain contributions that your Employer makes to the Plan. This means that you will not be "vested" in (entitled to) all of the contributions until you have been employed with the Employer for a specified period of time (see the Article entitled "Vesting"). If a Participant terminates employment before being fully vested, then the non-vested portion of the Terminated Participant's account balance remains in the Plan and is called a forfeiture.

Allocation of forfeitures. The Employer may use forfeitures to pay Plan expenses. In some cases, remaining forfeitures will be used to reduce Employer contributions.

ARTICLE III
COMPENSATION AND ACCOUNT BALANCE

What compensation is used to determine my Plan benefits?

Definition of compensation. For the purposes of the Plan, compensation has a special meaning. Compensation is generally defined as your total compensation that is subject to income tax and paid to you by your Employer during the Plan Year. In addition, salary reductions to any other plan or arrangement (such as a cafeteria plan) will be included in Compensation. If you are a self-employed individual, your compensation will be equal to your earned income. The following describes the adjustments to compensation that may apply under the Plan.

Adjustments to compensation. The following adjustments to compensation will be made:

- compensation paid while not a Participant in the component of the Plan for which compensation is being used will be excluded.

- compensation paid after you terminate employment is generally excluded for Plan purposes. However, the following amounts will be included in compensation even though they are paid after you terminate employment, provided these amounts would otherwise have been considered compensation as described above and provided they are paid within 2 1/2 months after you terminate employment, or if later, the last day of the Plan Year in which you terminate employment:

    - compensation for services performed during your regular working hours, or for services outside your regular working hours (such as overtime or shift differential) or other similar payments that would have been made to you had you continued employment

    - compensation paid for unused accrued bona fide sick, vacation or other leave, if such amounts would have been included in compensation if paid prior to your termination of employment and you would have been able to use the leave if employment had continued

    - nonqualified unfunded deferred compensation if the payment is includible in gross income and would have been paid to you had you continued employment

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Is there a limit on the amount of compensation which can be considered?

The Plan, by law, cannot recognize annual compensation in excess of a certain dollar limit. The limit for the Plan Year beginning in 2022 is $305,000. After 2022, the dollar limit may increase for cost-of-living adjustments.

Is there a limit on how much can be contributed to my account each year?

Generally, the law imposes a maximum limit on the amount of contributions that may be made to your account and any other amounts allocated to any of your accounts during the Plan Year, excluding earnings. Beginning in 2022, this total cannot exceed the lesser of $61,000 or 100% of your annual compensation. After 2022, the dollar limit may increase for cost-of-living adjustments.

How is the money in the Plan invested?

The Trustee of the Plan has been designated to hold the assets of the Plan for the benefit of Plan Participants and their beneficiaries in accordance with the terms of this Plan. The Trust Fund established by the Plan's Trustee will be the funding medium used for the accumulation of assets from which Plan benefits will be distributed.

The Trustee, Employer or another designated person or entity is responsible for the investment of assets held by the Plan. Investment decisions are made in the best interests of you and other Plan Participants. If you have any questions, contact the Administrator (or other Plan representative). The name and address of the Trustee can be found in the Article of this SPD entitled "General Information About The Plan."

Periodically, you will receive a benefit statement that provides information on your account balance and your investment returns. It is your responsibility to notify the Administrator of any errors you see on any statements within 30 days after the statement is provided or made available to you.

Will Plan expenses be deducted from my account balance?

Expenses allocated to all accounts. The Plan permits the payment of Plan expenses to be made from the Plan's assets. If expenses are paid using the Plan's assets, then the expenses will generally be allocated among the accounts of all Participants in the Plan. These expenses will be allocated either proportionately based on the value of the account balances or as an equal dollar amount based on the number of Participants in the Plan. The method of allocating the expenses depends on the nature of the expense itself. For example, certain administrative (or recordkeeping) expenses would typically be allocated proportionately to each Participant. If the Plan pays $1,000 in expenses and there are 100 Participants, your account balance would be charged $10 ($1,000/100) of the expense.

Terminated employee. After you terminate employment, your Employer reserves the right to charge your account for your pro rata share of the Plan's administration expenses, regardless of whether your Employer pays some of these expenses on behalf of current employees.

Expenses allocated to individual accounts. There are certain other expenses that may be paid just from your account. These are expenses that are specifically incurred by, or attributable to, you. For example, if you are married and get divorced, the Plan may incur additional expenses if a court mandates that a portion of your account be paid to your ex-spouse. These additional expenses may be paid directly from your account (and not the accounts of other Participants) because they are directly attributable to you under the Plan. The Administrator will inform you when there will be a charge (or charges) directly to your account.

Your Employer may, from time to time, change the manner in which expenses are allocated.

ARTICLE IV
VESTING

What is my vested interest in my account?

In order to reward employees who remain employed with the Employer for a long period of time, the law permits a "vesting schedule" to be applied to certain contributions that your Employer makes to the Plan. This means that you will not be entitled ("vested") in all of the contributions until you have been employed with the Employer for a specified period of time.

Vesting schedules. Your "vested percentage" for certain Employer contributions is based on vesting Years of Service. This means at the time you stop working, your account balance attributable to contributions subject to a vesting schedule is multiplied by your vested percentage. The result, when added to the amounts that are always 100% vested as shown above, is your vested interest in the Plan, which is what you will actually receive from the Plan.

Employer Profit Sharing Contributions

Your "vested percentage" in your account attributable to profit sharing contributions is determined under the following schedule. You will always, however, be 100% vested in your profit sharing contributions if you are employed on or after your Normal Retirement Age or if you die or become disabled.

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Vesting Schedule
Profit Sharing Contributions

Years of Service	Percentage
Less than 2	0%
2	20%
3	40%
4	60%
5	80%
6	100%

How is my service determined for vesting purposes?

Year of Service. To earn a Year of Service, you must be credited with at least 1,000 Hours of Service during a Plan Year. The Plan contains specific rules for crediting Hours of Service for vesting purposes. The Administrator will track your service and will credit you with a Year of Service for each Plan Year in which you are credited with the required Hours of Service, in accordance with the terms of the Plan. If you have any questions regarding your vesting service, you should contact the Administrator.

Hour of Service-employees for whom hourly records are kept. You will be credited with your actual Hours of Service for:

(a) each hour for which you are directly or indirectly compensated by the Employer for the performance of duties during the Plan Year;

(b) each hour for which you are directly or indirectly compensated by the Employer for reasons other than the performance of duties (such as vacation, holidays, sickness, disability, lay-off, military duty, jury duty or leave of absence during the Plan Year); and

(c) each hour for back pay awarded or agreed to by the Employer.

You will not be credited for the same Hours of Service both under (a) or (b), as the case may be, and under (c).

Hour of Service-employees for whom hourly records are not kept. The Plan does not credit you with your actual Hours of Service. Instead the Plan uses an "equivalency" method. Under this method you will be credited with 190 Hours of Service for each month during the year in which you would otherwise be credited with at least one Hour of Service.

What service is counted for vesting purposes?

Service with the Employer. In calculating your vested percentage, all service you perform for the Employer will generally be counted. However, there are some exceptions to this general rule.

Break in Service rules. If you terminate employment and are rehired, you may lose credit for prior service under the Plan's Break in Service rules.

For vesting purposes, you will have a 1-Year Break in Service if you complete less than 501 Hours of Service during the computation period used to determine whether you have a Year of Service. However, if you are absent from work for certain leaves of absence such as a maternity or paternity leave, you may be credited with enough Hours of Service to prevent a Break in Service.

Five-year Break in Service rule. The five-year Break in Service rule applies only to employees who had no vested interest in the Plan when employment had terminated. If you were not vested in any amounts when you terminated employment and you have five 1-Year Breaks in Service (as defined above), all the service you earned before the 5-year period no longer counts for vesting purposes. Thus, if you return to employment after incurring five 1-Year Breaks in Service, you will be treated as a new employee (with no service) for purposes of determining your vested percentage under the Plan.

Military service. If you are a veteran and are reemployed under the Uniformed Services Employment and Reemployment Rights Act of 1994, your qualified military service may be considered service with the Employer. If you may be affected by this law, ask the Administrator for further details.

What happens to my non-vested account balance if I'm rehired?

If you have no vested interest in the Plan when you leave, your account balance will be forfeited. However, if you are rehired before incurring five 1-Year Breaks in Service, your account balance as of your termination date will be restored, unadjusted for any gains or losses.

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If you are partially vested in your account balance when you leave, the non-vested portion of your account balance will be forfeited on the earlier of the date:

(a) of the distribution of your vested account balance, or

(b) when you incur five consecutive 1-Year Breaks in Service.

If you received a distribution of your vested account balance and are rehired, you may have the right to repay this distribution. If you repay the entire amount of the distribution, your Employer will restore your account balance with your forfeited amount. You must repay this distribution within five years from your date of reemployment, or, if earlier, before you incur five 1-Year Breaks in Service. If you were 100% vested when you left, you do not have the opportunity to repay your distribution.

What happens if the Plan becomes a "top-heavy plan"?

Top-heavy plan. A retirement plan that primarily benefits "key employees" is called a "top-heavy plan." "Key employees" are certain owners or officers of your Employer. A plan is generally a "top-heavy plan" when more than 60% of the plan assets are attributable to "key employees." Each year, the Administrator is responsible for determining whether the Plan is a "top-heavy plan."

Top-heavy rules. If the Plan becomes top-heavy in any Plan Year, then non-key employees may be entitled to certain "top-heavy minimum benefits," and other special rules will apply. These top-heavy rules include the following:

- Your Employer may be required to make a contribution on your behalf in order to provide you with at least "top-heavy minimum benefits."
- If you are a Participant in more than one Plan, you may not be entitled to "top-heavy minimum benefits" under both Plans.

ARTICLE V
DISTRIBUTIONS PRIOR TO TERMINATION

Can I withdraw money from my account while working?

In-service distributions. You may be entitled to receive an in-service distribution. However, this distribution is not in addition to your other benefits and will therefore reduce the value of the benefits you will receive at retirement. This distribution is made at your election and will be made in accordance with the forms of distributions available under the Plan.

Conditions and limitations. Generally you may receive a distribution from the Plan from certain accounts prior to your termination of employment provided you satisfy the condition described below:

- you have reached Normal Retirement Age

ARTICLE VI
BENEFITS AND DISTRIBUTIONS UPON TERMINATION OF EMPLOYMENT

When can I get money out of the Plan?

You may receive a distribution of the vested portion of some or all of your accounts in the Plan for the following reasons:

- termination of employment for reasons other than death, disability or retirement
- normal retirement
- disability
- death

This Plan is designed to provide you with retirement benefits. However, distributions are permitted if you die or become disabled. In addition, certain payments are permitted when you terminate employment for any other reason. The rules under which you can receive a distribution are described in this Article. The rules regarding the payment of death benefits to your beneficiary are described in "Benefits and Distributions Upon Death."

You may also receive distributions while you are still employed with the Employer. (See the Article entitled "Distributions Prior to Termination" for a further explanation.)

Military service. If you are a veteran and are reemployed under the Uniformed Services Employment and Reemployment Rights Act of 1994, your qualified military service may be considered service with the Employer. There may also be benefits for employees who die or

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become disabled while on active duty. Employees who receive wage continuation payments while in the military may benefit from various changes in the law. If you think you may be affected by these rules, ask the Administrator for further details.

Distributions for deemed severance of employment. If you are on active duty for more than 30 days, then the Plan generally treats you as having severed employment for distribution purposes. This means that you may request a distribution from the Plan. If you request a distribution on account of this deemed severance of employment, then you are not permitted to make any contributions to the Plan for six (6) months after the date of the distribution.

What happens if I terminate employment before death, disability or retirement?

If your employment terminates for reasons other than death, disability or normal retirement, you will be entitled to receive only the "vested percentage" of your account balance.

You may elect to have your vested account balance distributed to you as soon as administratively feasible after the last day of the Plan Year coinciding with or next following the date on which you terminate employment. However, if the value of your vested account balance does not exceed $1,000, then a distribution will be made to you regardless of whether you consent to receive it. (See the question entitled "How will my benefits be paid to me?" for additional information.)

What happens if I terminate employment at Normal Retirement Date?

Normal Retirement Date. You will attain your Normal Retirement Age when you reach age 65, or your 5th anniversary of joining the Plan, if later. Your Normal Retirement Date is the date on which you attain your Normal Retirement Age.

Payment of benefits. You will become 100% vested in all of your accounts under the Plan once you attain your Normal Retirement Age. However, the actual payment of benefits generally will not begin until you reach your Normal Retirement Date (even if employment has not terminated). In such event, a distribution will be made, at your election, as soon as administratively feasible. If you remain employed past your Normal Retirement Date, you may generally defer the receipt of benefits until you actually terminate employment. In such event, benefit payments will begin as soon as feasible at your request, but generally not later than age 70 1/2. (See the question entitled "How will my benefits be paid to me?" for an explanation of how these benefits will be paid.)

What happens if I terminate employment due to disability?

Definition of disability. Under the Plan, disability is defined as a physical or mental condition resulting from bodily injury, disease, or mental disorder which renders you incapable of continuing any gainful occupation and which has lasted or can be expected to last for a continuous period of at least twelve (12) months. Your disability must be determined by a licensed physician. However, if your condition constitutes total disability under the federal Social Security Act, then the Administrator may deem that you are disabled for purposes of the Plan.

Payment of benefits. If you become disabled while an employee, you will become 100% vested in all of your accounts under the Plan. Payment of your disability benefits will be made to you as if you had retired. However, if the value of your account balance does not exceed $1,000, then a distribution of your account balance will be made to you, regardless of whether you consent to receive it. (See the question entitled "How will my benefits be paid to me?" for an explanation of how these benefits will be paid.)

How will my benefits be paid to me?

Forms of distribution. If your vested account balance does not exceed $5,000, then your vested account balance may only be distributed to you in a single lump-sum payment.

In addition, if your vested account balance exceeds $1,000, you must consent to any distribution before it may be made. If your vested account balance exceeds $5,000, you may elect to receive a distribution of your vested account balance in:

- a single lump-sum payment
- partial withdrawals or installments but only with respect to Participants or beneficiaries who must receive minimum required distributions, over a period of not more than your assumed life expectancy (or the assumed life expectancies of you and your beneficiary). (See below "Delaying distributions." for an explanation of minimum required distributions.)

Delaying distributions. You may delay the distribution of your vested account balance unless a distribution is required to be made, as explained earlier, because your vested account balance does not exceed $1,000. However, if you elect to delay the distribution of your vested account balance, there are rules that require that certain minimum distributions be made from the Plan. If you are a 5% owner, distributions are required to begin not later than the April 1st following the end of the year in which you reach age 70 1/2. If you are not a 5% owner, distributions are required to begin not later than the April 1st following the later of the end of the year in which you reach age 70 1/2 or retire. You should contact the Administrator if you think you may be affected by these rules.

Medium of payment. Benefits under the Plan will generally be paid to you in cash only.

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ARTICLE VII
BENEFITS AND DISTRIBUTIONS UPON DEATH

What happens if I die while working for the Employer?

If you die while still employed by the Employer, then your vested account balance will be used to provide your beneficiary with a death benefit.

Who is the beneficiary of my death benefit?

Married Participant. If you are married at the time of your death, your spouse will be the beneficiary of the entire death benefit unless an election is made to change the beneficiary. IF YOU WISH TO DESIGNATE A BENEFICIARY OTHER THAN YOUR SPOUSE, YOUR SPOUSE (IF YOU ARE MARRIED) MUST IRREVOCABLY CONSENT TO WAIVE ANY RIGHT TO THE DEATH BENEFIT. YOUR SPOUSE'S CONSENT MUST BE IN WRITING, BE WITNESSED BY A NOTARY OR A PLAN REPRESENTATIVE AND ACKNOWLEDGE THE SPECIFIC NONSPOUSE BENEFICIARY.

If you are married and you change your designation, then your spouse must again consent to the change. In addition, you may elect a beneficiary other than your spouse without your spouse's consent if your spouse cannot be located.

Unmarried Participant. If you are not married, you may designate a beneficiary on a form to be supplied to you by the Administrator.

Divorce. If you have designated your spouse as your beneficiary for all or a part of your death benefit, then upon your divorce, the designation is no longer valid. This means that if you do not select a new beneficiary after your divorce, then you are treated as not having a beneficiary for that portion of the death benefit (unless you have remarried).

No beneficiary designation. At the time of your death, if you have not designated a beneficiary or your beneficiary is also not alive, the death benefit will be paid in the following order of priority to:

(a) your surviving spouse

(b) your children, including adopted children in equal shares (and if a child is not living, that child's share will be distributed to that child's heirs)

(c) your surviving parents, in equal shares

(d) your estate

How will the death benefit be paid to my beneficiary?

Form of distribution. If the death benefit payable to a beneficiary does not exceed $5,000, then the benefit may only be paid as a lump-sum. If the death benefit exceeds $5,000, your beneficiary may elect to have the death benefit paid in:

- a single lump-sum payment
- partial withdrawals or installments that do not exceed the limitations on when the entire death benefit must be paid. (See below "When must the last payment be made to my beneficiary?")

When must the last payment be made to my beneficiary?

The law generally restricts the ability of a retirement plan to be used as a method of retaining money for purposes of your death estate. Thus, there are rules that are designed to ensure that death benefits are distributable to beneficiaries within certain time periods.

Regardless of the method of distribution selected, if your designated beneficiary is a person (rather than your estate or some trusts) then minimum distributions of your death benefit will begin by the end of the year following the year of your death ("1-year rule") and must be paid over a period not extending beyond your beneficiary's life expectancy. If your spouse is the beneficiary, then under the "1-year rule," the start of payments will be delayed until the year in which you would have attained age 70 1/2 unless your spouse elects to begin distributions over his or her life expectancy before then. However, instead of the "1-year rule" your beneficiary may elect to have the entire death benefit paid by the end of the fifth year following the year of your death (the "5-year rule"). Generally, if your beneficiary is not a person, your entire death benefit must be paid under the "5-year rule."

Since your spouse has certain rights to the death benefit, you should immediately report any change in your marital status to the Administrator.

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What happens if I'm a Participant, terminate employment and die before receiving all my benefits?

If you terminate employment with the Employer and subsequently die, your beneficiary will be entitled to your remaining interest in the Plan at the time of your death. The provision in the Plan providing for full vesting of your benefit upon death does not apply if you die after terminating employment.

ARTICLE VIII
TAX TREATMENT OF DISTRIBUTIONS

What are my tax consequences when I receive a distribution from the Plan?

Generally, you must include any Plan distribution in your taxable income in the year in which you receive the distribution. The tax treatment may also depend on your age when you receive the distribution. Certain distributions made to you when you are under age 59 1/2 could be subject to an additional 10% tax.

Can I elect a rollover to reduce or defer tax on my distribution?

Rollover or direct transfer. You may reduce, or defer entirely, the tax due on your distribution through use of one of the following methods:

60-day rollover. The rollover of all or a portion of the distribution to an individual retirement account or annuity (IRA) or another employer retirement plan willing to accept the rollover. This will result in no tax being due until you begin withdrawing funds from the IRA or other qualified employer plan. The rollover of the distribution, however, MUST be made within strict time frames (normally, within 60 days after you receive your distribution). Under certain circumstances, all or a portion of a distribution may not qualify for this rollover treatment. In addition, most distributions will be subject to mandatory federal income tax withholding at a rate of 20%. This will reduce the amount you actually receive. For this reason, if you wish to roll over all or a portion of your distribution amount, then the direct transfer option described below would be the better choice.

Direct rollover. For most distributions, you may request that a direct transfer (sometimes referred to as a "direct rollover") of all or a portion of a distribution be made to either an individual retirement account or annuity (IRA) or another employer retirement plan willing to accept the transfer. A direct transfer will result in no tax being due until you withdraw funds from the IRA or other employer plan. Like the rollover, under certain circumstances all or a portion of the amount to be distributed may not qualify for this direct transfer. If you elect to actually receive the distribution rather than request a direct transfer, then in most cases 20% of the distribution amount will be withheld for federal income tax purposes.

Tax Notice. WHENEVER YOU RECEIVE A DISTRIBUTION THAT IS AN ELIGIBLE ROLLOVER DISTRIBUTION, THE ADMINISTRATOR WILL DELIVER TO YOU A MORE DETAILED EXPLANATION OF THESE OPTIONS. HOWEVER, THE RULES WHICH DETERMINE WHETHER YOU QUALIFY FOR FAVORABLE TAX TREATMENT ARE VERY COMPLEX. YOU SHOULD CONSULT WITH QUALIFIED TAX COUNSEL BEFORE MAKING A CHOICE.

ARTICLE IX
PROTECTED BENEFITS AND CLAIMS PROCEDURES

Are my benefits protected?

As a general rule, your interest in your account, including your "vested interest," may not be alienated. This means that your interest may not be sold, used as collateral for a loan, given away or otherwise transferred. In addition, your creditors (other than the IRS) may not attach, garnish or otherwise interfere with your benefits under the Plan.

Are there any exceptions to the general rule?

There are three exceptions to this general rule. The Administrator must honor a "qualified domestic relations order." A "qualified domestic relations order" is defined as a decree or order issued by a court that obligates you to pay child support or alimony, or otherwise allocates a portion of your assets in the Plan to your spouse, former spouse, children or other dependents. If a "qualified domestic relations order" is received by the Administrator, all or a portion of your benefits may be used to satisfy that obligation. The Administrator will determine the validity of any domestic relations order received. You and your beneficiaries can obtain from the Administrator, without charge, a copy of the procedure used by the Administrator to determine whether a "qualified domestic relations order" is valid.

The second exception applies if you are involved with the Plan's operation. If you are found liable for any action that adversely affects the Plan, the Administrator can offset your benefits by the amount that you are ordered or required by a court to pay the Plan. All or a portion of your benefits may be used to satisfy any such obligation to the Plan.

The last exception applies to federal tax levies and judgments. The federal government is able to use your interest in the Plan to enforce a federal tax levy and to collect a judgment resulting from an unpaid tax assessment.

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Can the Plan be amended?

Your Employer has the right to amend the Plan at any time. In no event, however, will any amendment authorize or permit any part of the Plan assets to be used for purposes other than the exclusive benefit of Participants or their beneficiaries. Additionally, no amendment will cause any reduction in the amount credited to your account.

What happens if the Plan is discontinued or terminated?

Although your Employer intends to maintain the Plan indefinitely, your Employer reserves the right to terminate the Plan at any time. Upon termination, no further contributions will be made to the Plan and all amounts credited to your accounts will become 100% vested. Your Employer will direct the distribution of your accounts in a manner permitted by the Plan as soon as practicable. (See the question entitled "How will my benefits be paid to me?" for a further explanation.) You will be notified if the Plan is terminated.

How do I submit a claim for Plan benefits?

You may file a claim for benefits by submitting a written request for benefits to the Plan Administrator. You should contact the Plan Administrator to see if there is an applicable distribution form that must be used. If no specific form is required or available, then your written request for a distribution will be considered a claim for benefits. In the case of a claim for disability benefits, if disability is determined by the Plan Administrator (rather than by a third party such as the Social Security Administration), then you must also include with your claim sufficient evidence to enable the Plan Administrator to make a determination on whether you are disabled.

Decisions on the claim will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days. If the Plan Administrator determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

For purposes of the claims procedures described below, "you" refers to you, your authorized representative, or anyone else entitled to benefits under the Plan (such as a beneficiary). A document, record, or other information will be considered relevant to a claim if it:

- was relied upon in making the benefit determination;
- was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The Plan may offer additional voluntary appeal and/or mandatory arbitration procedures other than those described below. If applicable, the Plan will not assert that you failed to exhaust administrative remedies for failure to use the voluntary procedures, any statute of limitations or other defense based on timeliness is tolled during the time a voluntary appeal is pending; and the voluntary process is available only after exhaustion of the appeals process described in this section. If mandatory arbitration is offered by the Plan, the arbitration must be conducted instead of the appeal process described in this section, and you are not precluded from challenging the decision under ERISA §501(a) or other applicable law.

What if my benefits are denied?

Your request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If your claim is wholly or partially denied, the Administrator will provide you with a written or electronic notification of the Plan's adverse determination. This written or electronic notification must be provided to you within a reasonable period of time, but not later than 90 days (except as provided below for disability claims) after the receipt of your claim by the Administrator, unless the Administrator determines that special circumstances require an extension of time for processing your claim. If the Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 90-day period. In no event will such extension exceed a period of 90 days from the end of such initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

In the case of a claim for disability benefits, if disability is determined by the Plan Administrator (rather than a third party such as the Social Security Administration), then instead of the above, the initial claim must be resolved within 45 days of receipt by the Plan. A Plan may, however, extend this decision-making period for an additional 30 days for reasons beyond the control of the Plan. The Plan will notify you of the extension prior to the end of the 45-day period. If, after extending the time period for a first period of 30 days, the Plan Administrator determines that it will still be unable, for reasons beyond the control of the Plan, to make a decision within the extension period, the Plan may extend decision making for a second 30-day period. Appropriate notice will be provided to you before the end of the first 45 days and again before the end of each succeeding 30-day period. This notice will explain the circumstances requiring the extension and the date the Plan Administrator expects to render a decision. It will explain the standards on which entitlement to the benefits is based,

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the unresolved issues that prevent a decision, the additional issues that prevent a decision, and the additional information needed to resolve the issues. You will have 45 days from the date of receipt of the Plan Administrator's notice to provide the information required.

If the Plan Administrator determines that all or part of the claim should be denied (an "adverse benefit determination"), it will provide a notice of its decision in written or electronic form explaining your appeal rights. An "adverse benefit determination" also includes a rescission, which is a retroactive cancellation or termination of entitlement to disability benefits. The notice will be provided in a culturally and linguistically appropriate manner and will state:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the determination was based.

(c) A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

(d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

(e) In the case of a claim for disability benefits if disability is determined by the Plan Administrator (rather than a third party such as the Social Security Administration), then the following additional information will be provided:

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- The views you presented to the Plan of health care professionals treating the claimant and vocational professionals who evaluated you;
- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or
- A disability determination made by the Social Security Administration and presented by you to the Plan.

(ii) Either the internal rules, guidelines, protocols, or other similar criteria relied upon to make a determination, or a statement that such rules, guidelines, protocols, or other criteria do not exist.

(iii) If the adverse benefit determination is based on a medical necessity or experimental treatment and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances. If this is not practical, a statement will be included that such explanation will be provided to you free of charge, upon request.

(iv) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

If your claim has been denied, and you want to submit your claim for review, you must follow the Claims Review Procedure in the next question.

What is the Claims Review Procedure?

Upon the denial of your claim for benefits, you may file your claim for review, in writing, with the Administrator.

(a) YOU MUST FILE THE CLAIM FOR REVIEW NOT LATER THAN 60 DAYS (EXCEPT AS PROVIDED BELOW FOR DISABILITY CLAIMS) AFTER YOU HAVE RECEIVED WRITTEN NOTIFICATION OF THE DENIAL OF YOUR CLAIM FOR BENEFITS.

IF YOUR CLAIM IS FOR DISABILITY BENEFITS AND DISABILITY IS DETERMINED BY THE PLAN ADMINISTRATOR (RATHER THAN A THIRD PARTY SUCH AS THE SOCIAL SECURITY ADMINISTRATION), THEN INSTEAD OF THE ABOVE, YOU MUST FILE THE CLAIM FOR REVIEW NOT LATER THAN 180 DAYS FOLLOWING RECEIPT OF NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION. IN THE CASE OF AN ADVERSE BENEFIT DETERMINATION REGARDING A RESCISSION OF COVERAGE, YOU MUST REQUEST A REVIEW WITHIN 90 DAYS OF THE NOTICE.

(b) You may submit written comments, documents, records, and other information relating to your claim for benefits.

(c) You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

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(d) Your claim for review must be given a full and fair review. This review will take into account all comments, documents, records, and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition to the Claims Review Procedure above, if your claim is for disability benefits and disability is determined by the Plan Administrator (rather than a third party such as the Social Security Administration), then:

(a) Your claim will be reviewed without deference to the initial adverse benefit determination and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

(b) If the initial adverse benefit determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary will consult with a health care professional who was neither involved in or subordinate to the person who made the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

(c) Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination will be identified, without regard to whether the advice was relied upon in making the benefit determination.

(d) If the Plan considers, relies upon or creates any new or additional evidence during the review of the adverse benefit determination, the Plan will provide such new or additional evidence to you, free of charge, as soon as possible and sufficiently in advance of the time within which a determination on review is required to allow you time to respond.

(e) Before the Plan issues an adverse benefit determination on review that is based on a new or additional rationale, the Plan Administrator must provide you with a copy of the rationale at no cost to you. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on appeal is required to allow you time to respond.

The Administrator will provide you with written or electronic notification of the Plan's benefit determination on review. The Administrator must provide you with notification of this denial within 60 days (45 days with respect to claims relating to the determination of disability benefits) after the Administrator's receipt of your written claim for review, unless the Administrator determines that special circumstances require an extension of time for processing your claim. In such a case, you will be notified, before the end of the initial review period, of the special circumstances requiring the extension and the date a decision is expected. If an extension is provided, the Plan Administrator must notify you of the determination on review no later than 120 days (or 90 days with respect to claims relating to the determination of disability benefits).

The Plan Administrator will provide written or electronic notification to you in a culturally and linguistically appropriate manner. If the initial adverse benefit determination is upheld on review, the notice will include:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the benefit determination was based.

(c) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

(d) In the case of a claim for disability benefits, if disability is determined by the Plan Administrator (rather than a third party such as the Social Security Administration):

(i) Either the specific internal rules, guidelines, protocols, or other similar criteria relied upon to make the determination, or a statement that such rules, guidelines, protocols, or criteria do not exist.

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances. If this is not practical, a statement will be included that such explanation will be provided to you free of charge, upon request.

(iii) A statement of your right to bring a civil action under section 502(a) of ERISA and, if the Plan imposes a contractual limitations period that applies to your right to bring such an action, a statement to that effect which includes the calendar date on which such limitation expires on the claim.

If the Plan offers voluntary appeal procedures, a description of those procedures and your right to obtain sufficient information about those procedures upon request to enable you to make an informed decision about whether to submit to such voluntary

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appeal. These procedures will include a description of your right to representation, the process for selecting the decision maker and the circumstances, if any, that may affect the impartiality of the decision maker. No fees or costs will be imposed on you as part of the voluntary appeal. A decision whether to use the voluntary appeal process will have no effect on your rights to any other Plan benefits.

(iv) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- the views presented by the claimant to the Plan of health care professionals treating you and vocational professionals who evaluated you;
- the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or
- a disability determination made by the Social Security Administration and presented by you to the Plan.

If you have a claim for benefits which is denied, then you may file suit in a state or federal court. However, in order to do so, you must file the suit not later than 180 days after the Administrator makes a final determination to deny your claim.

What are my rights as a Plan Participant?

As a Participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to:

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

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

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

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. You and your beneficiaries can obtain, without charge, a copy of the "qualified domestic relations order" (QDRO) procedures from the Administrator.

If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. The court may order you to pay these costs and fees if you lose or if, for example, it finds your claim is frivolous.

What can I do if I have questions or my rights are violated?

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W.,

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Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE X
GENERAL INFORMATION ABOUT THE PLAN

There is certain general information which you may need to know about the Plan. This information has been summarized for you in this Article.

Plan Name

The full name of the Plan is American Legacy Stucco & Stone, Inc. Defined Contribution Plan.

Plan Number

Your Employer has assigned Plan Number 001 to your Plan.

Plan Effective Dates

Effective Date. This Plan was originally effective on January 1, 2015. The amended and restated provisions of the Plan become effective on January 1, 2021. However, this restatement was made to conform the Plan to new tax laws and some provisions may be retroactively effective.

Other Plan Information

Valuation date. Valuations of the Plan assets are generally made annually on the last day of the Plan Year. Certain distributions are based on the Anniversary Date of the Plan. This date is the last day of the Plan Year.

Plan Year. The Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1st and ends on December 31st.

The Plan will be governed by the laws of Arizona to the extent not governed by federal law.

Benefits provided by the Plan are NOT insured by the Pension Benefit Guaranty Corporation (PBGC) under Title IV of the Employee Retirement Income Security Act of 1974 because the insurance provisions under ERISA are not applicable to this type of Plan.

Service of legal process may be made upon your Employer. Service of legal process may also be made upon the Trustee or Administrator.

Employer Information

Your Employer's name, contact information and identification number are:

American Legacy Stucco & Stone, Inc.
12455 North 92nd Drive Building B, Suite 103
Peoria, Arizona 85381
27-3892368
Telephone: (480) 253-0847

Administrator Information

The Administrator is responsible for the day-to-day administration and operation of the Plan. For example, the Administrator maintains the Plan records, including your account information, provides you with the forms you need to complete for Plan participation, and directs the payment of your account at the appropriate time. The Administrator will also allow you to review the formal Plan document and certain other materials related to the Plan. If you have any questions about the Plan or your participation, you should contact the Administrator. The Administrator may designate other parties to perform some duties of the Administrator.

The Administrator has the complete power, in its sole discretion, to determine all questions arising in connection with the administration, interpretation, and application of the Plan (and any related documents and underlying policies). Any such determination by the Administrator is conclusive and binding upon all persons.

Your Administrator's name and contact information are:

American Legacy Stucco & Stone, Inc.
12455 North 92nd Drive Building B, Suite 103
Peoria, Arizona 85381

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Telephone: (480) 253-0847

Plan Trustee Information and Plan Funding Medium

All money that is contributed to the Plan is held in a Trust Fund. The Trustee is responsible for the safekeeping of the Trust Fund. The Trust Fund is the funding medium used for the accumulation of assets from which benefits will be distributed. While all the Plan assets are held in a Trust Fund, the Administrator separately accounts for each Participant's interest in the Plan.

The Plan's Trustee is listed below with their contact information:

John Harrington, Trustee

12455 North 92nd Drive Building B, Suite 103
Peoria, Arizona 85381
Telephone: (480) 253-0847

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