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,

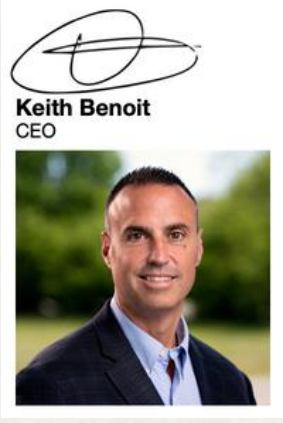
Our success at American Legacy Stucco and Stone (“American Legacy” or “the Company”) is built on the hard work and dedication of our employees. Each of you plays an important role in the quality of our projects and the strength of our reputation, and we want to make sure you feel valued and supported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

DISCLAIMERS

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.

The individually purchased additional insurance plans offered through Allstate are provided through our partnership with

intuit quickbooks

Please enroll any time through your Workforce App.

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 December first and runs through November.

Our 2025 plan year is
12/01/2024 - 11/30/2025

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
- 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 Optic

Summary of Benefits	MEC Basic	MEC Enhanced
Calendar-Year Deductible	None	None
Max Out of Pocket	None	None
Coinsurance	None	None
TeleMedicine	No Copay	No 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)	**10.16**	**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 HEALTH

BlueCross BlueShield

EMI BCBS ($5,000 / $10,000)

In-Network	Out-of-Network	
$5,000 / $10,000	$10,000 / $20,000	Calendar-Year Deductible
$7,500 / $15,000	$15,000 / $30,000	Max Out of Pocket
100% after deductible	50% after deductible	Coinsurance
Not Covered	Not Covered	TeleMedicine
Covered 100%	Not Covered	Preventive Care
$30 Copay	50% after deductible	Primary Care Visit
$60 Copay	50% after deductible	Specialist Visit
$75 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)
$400 Copay	$400 Copay	Emergency Room
		Prescription/Mail Order*
$15 Copay	10%	Tier 1 - Generic
$40 Copay	50%	Tier 2 - Preferred
$80 Copay	Discount Only	Tier 3 - Non-Preferred
		Speciality Prescriptions
25%, $150 max/yr		Tier 1 - Generic
25%, $250 max/yr		Tier 2 - Preferred
30%, $500 max/yr		Tier 3 - Non-Preferred
		Your Cost per Pay Period
181.25		Employee Only
394.58		Employee + Spouse
355.79		Employee + Child(ren)
607.91		Employee + Family

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

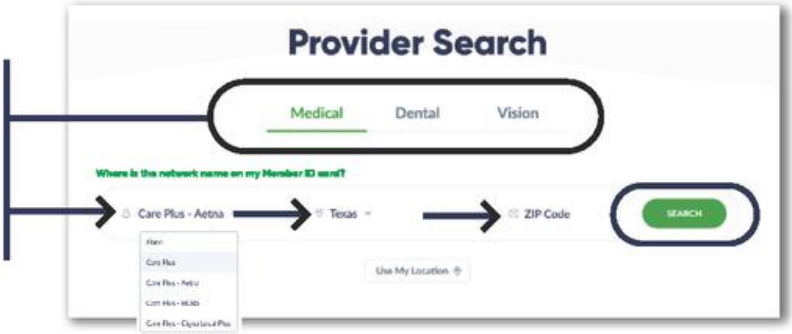
Online Services

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.

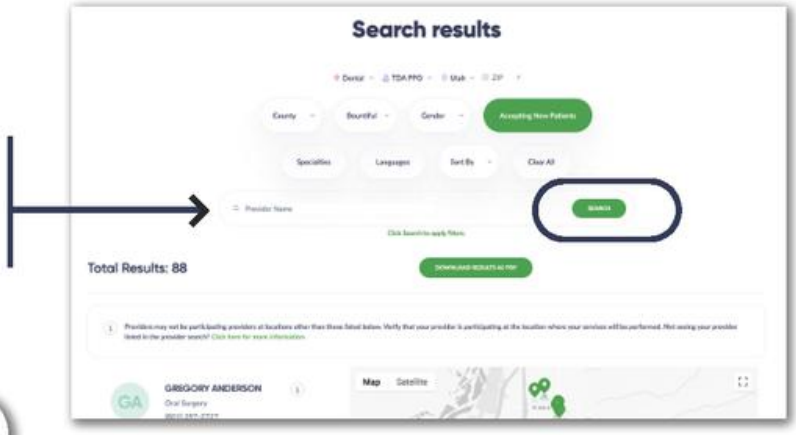
1 Go to **emihealth.com** and click on **+ FIND A PROVIDER** along the upper part of the home page, or use the green button below.

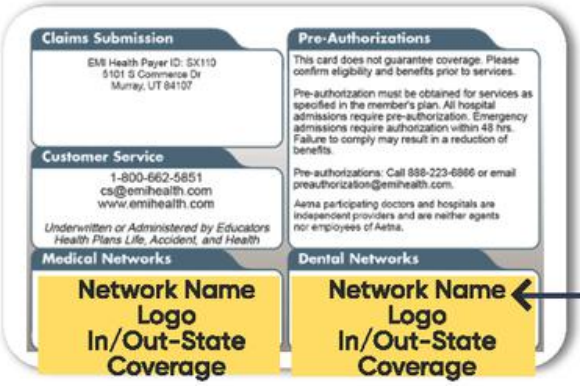
2 Click on either the **MEDICAL, DENTAL,** or **VISION** tab, Choose your **NETWORK NAME** (see note below on how to locate your network) from the drop down menu, Choose your **STATE**, and click **SEARCH**.



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**

EMI.MKTG.PROVIDERSEARCH.1023.1412

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

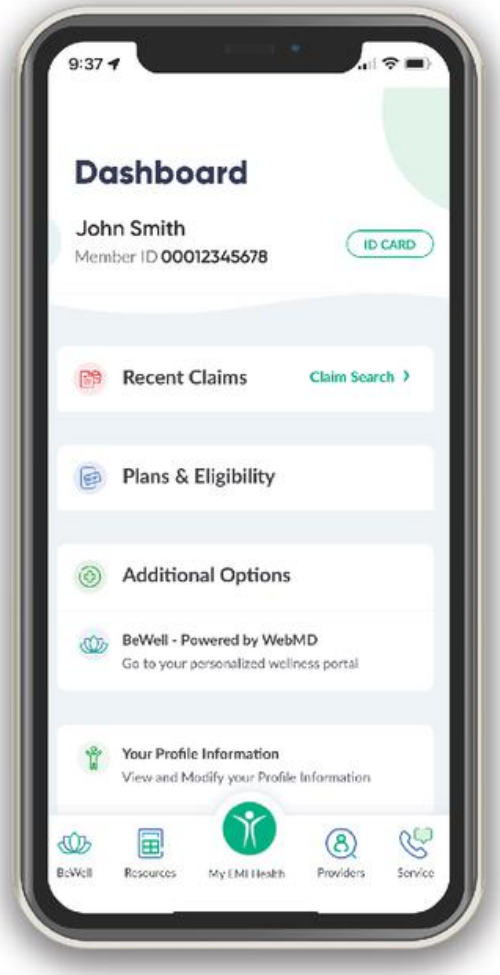
View and download your plan grids.

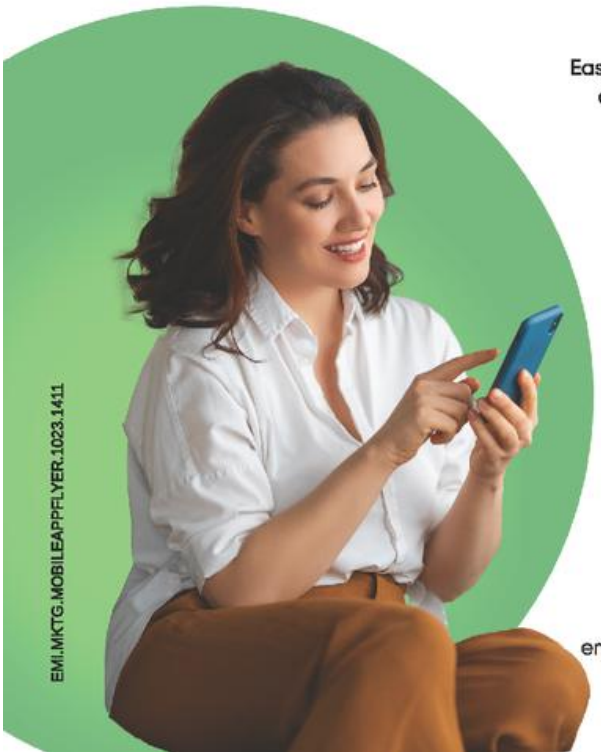
Profile

Update information like email address, password, or security.

Provider Search

Easily search for participating providers along with their contact information.





Scan this QR code with your phone to download.

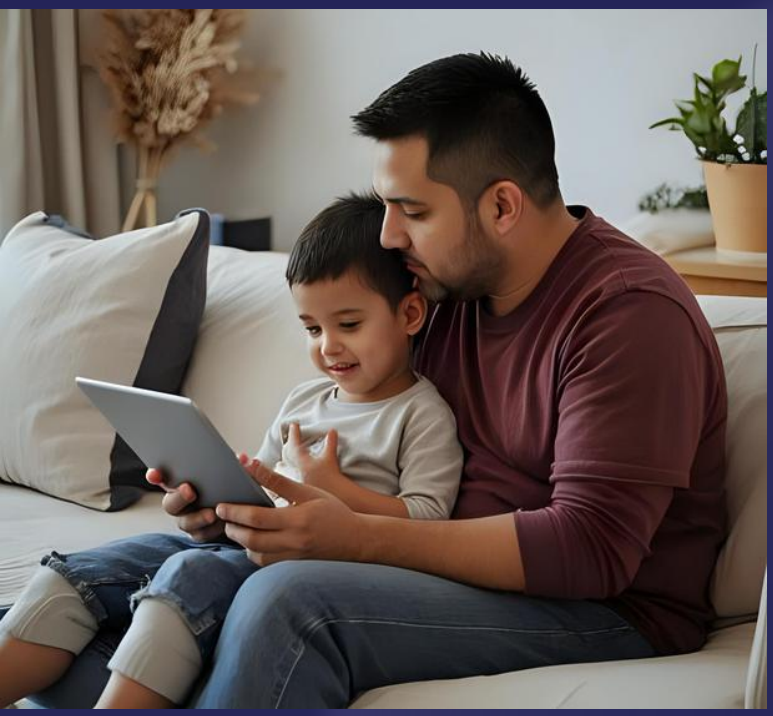
emihealth.com | (800) 662-5851 | 5101 S Commerce Drive Murray, UT 84107

EMI.MKTG.MOBILEAPPFLYER.1023.1411

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

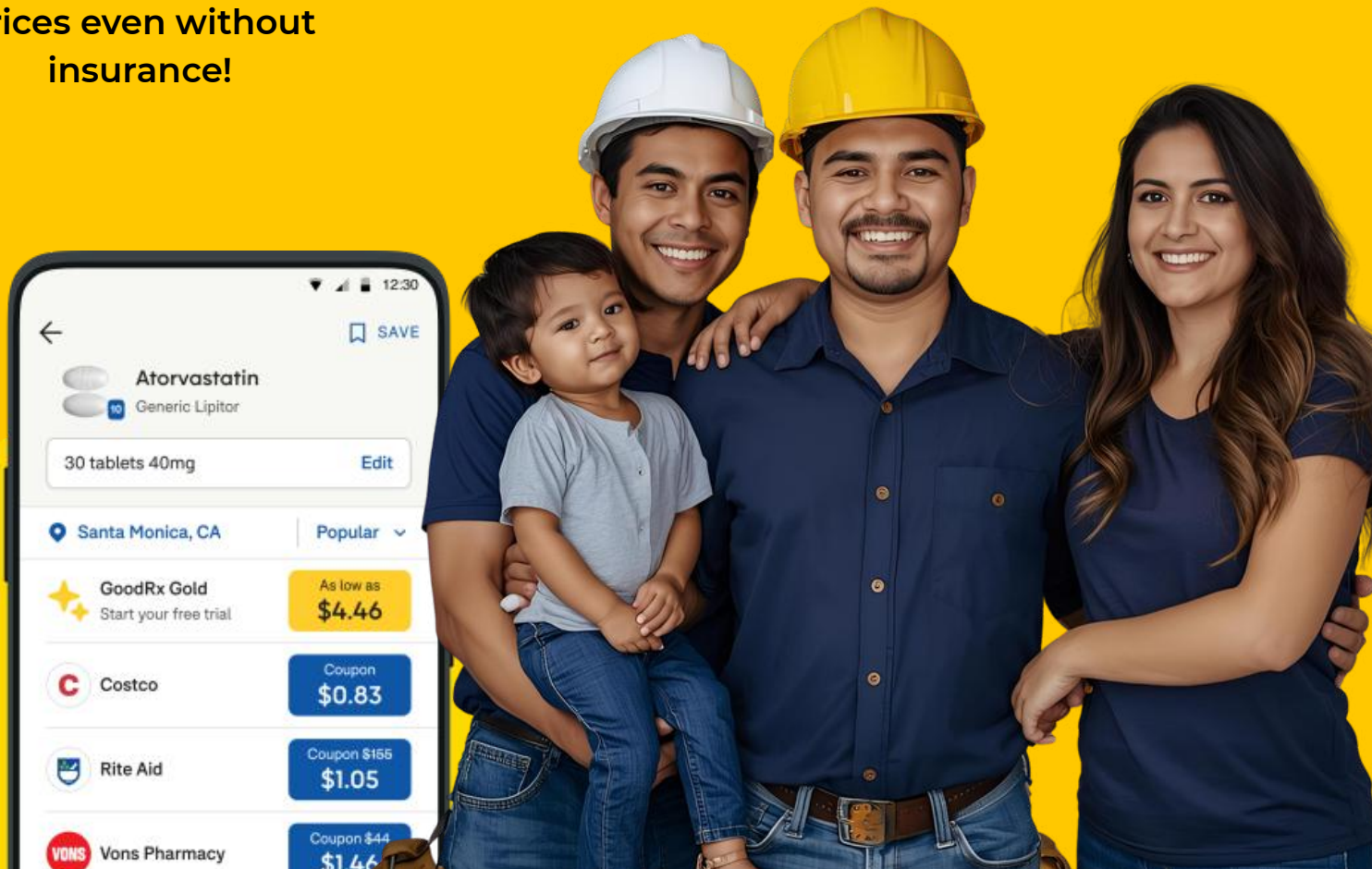
Drug prices vary by pharmacy. Use GoodRx to find current prices and discounts that are **often lower than cash prices even without insurance!**

Get Free Coupons

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

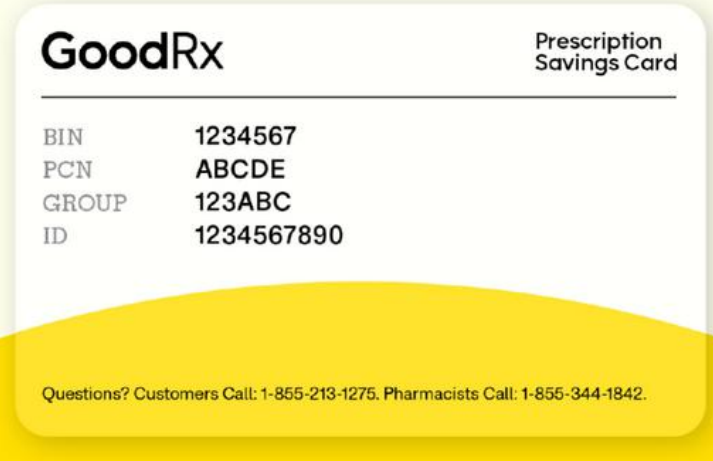
Use at Pharmacy

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

Questions?

Talk to the insurance pros at

reseco

EMI HEALTH

BlueCross BlueShield

In addition to your American Legacy HR team, who remain available at HR@american-stucco.com, you also have access to the professional benefits team at Reseco Insurance Advisors.

Reseco partners with us to design and manage our benefits package. They are experts in health insurance and are the best resource for assistance with complex billing or claims questions.

reseco

BETTER BUSINESSES BETTER LIVES

Savana York
Client Manager
602-753-4271
syork@resecoadvisors.com

Nichol Bingham
Assistant Acct Manager
602-753-4302
nbingham@resecoadvisors.com

INTUIT quickbooks

As an American Legacy employee, you have access to additional benefits through our partnership with Quickbooks Workforce.

Because they are voluntary, post-tax products, most can be elected at any time during employment through the Workforce app. Most Allstate plans are portable, meaning you may keep them and simply transition to personal billing if your employment with us ends.

Please reference your Workforce app for more details.


Dental


Vision


Accident


Critical Illness


Term Life

Still need the App?

A registration link was sent as part of your initial onboarding. If you can't find it or run into trouble while registering, please email us at HR@american-stucco.com for further assistance.

Available on the App Store

Get it on Google play

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 workforce 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 our Intuit Workforce 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

resecō

AND

modrnHR
CONSULTING & TRAINING

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

AMERICAN LEGACY STUCCO & STONE

HEALTH PLAN ENROLLMENT

241

Drop-Down: Initial Enrollment / Change Form

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 INFORMATION

Interactive on fillable form

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

Drop-Down: Initial Waiver / Change Form

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

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

☐ Medical

Drop-Down: I HAVE/do NOT have other insurance coverage

3 CERTIFICATION & ACKNOWLEDGEMENTS

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

Employee Signature

Date

4 EMPLOYER SIGN-OFF

Approved By

Approved On

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

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.

WRAP SDP

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: **$5,000 person / $10,000 family for calendar year** For non-participating providers: **$10,000 person / $20,000 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 is 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: **$5,000 person / $10,000 family** For non-participating providers: **$15,000 person / $30,000 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, 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	No charge after deductible	50% coinsurance	——————none——————
	Specialist visit	No charge after deductible	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 after deductible/ office visit No charge after deductible/ outpatient visit No charge after deductible/ inpatient services	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	No charge after deductible	50% coinsurance	Requires preauthorization

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	No charge after deductible prescription Retail No charge after deductible 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	No charge after deductible prescription Retail No charge after deductible 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	No charge after deductible prescription Retail No charge after deductible 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	No charge after deductible prescription Mail Order	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	No charge after deductible	No charge after deductible	——————none——————
	Urgent care	No charge after deductible	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	No charge after deductible office visit and 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	No charge after deductible	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: No charge after deductible	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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Infertility treatment
- Long-term care
- 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.)

- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- 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? **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.

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	**$5,000**
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	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	**$5,000**
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	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	**$5,070**

Mia's Simple Fracture

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

The plan's overall deductible	**$5,000**
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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

SCB - MEC BASIC

SCB - MEC ENHANCED

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.

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	602-799-0513
7. City	**8. State** / **9. ZIP Code**
Peoria	AZ / 85381
10. Who can we contact about employee health coverage at this job?	
Human Resources at: HR@american-stucco.com	
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, 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:

- 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.
- American Legacy Stucco and Stone, Inc. offers multiple plans and has determined that prescription drug coverage for the:
  - EMI BCBS (5,000/10,000) Health Plan, on average for all plan participants, is 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.**
- 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, 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.