ALLIED
INTERIORS GROUP

Allied Stone | Allied Gallery | Square Cabinetry | Allied Interior Solutions

2026 Benefits Guide

Table of Contents

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage.
Please see page 49 for more details.

A Message to Our Employees

2026 Allied Interiors Group Benefits

Allied Interiors Group recognizes the increasing costs associated with healthcare, influenced by factors such as inflation and regulatory changes. In response to these rising costs and industry-wide trends, the company remains dedicated to offering a comprehensive benefits package to its employees. As part of this commitment, the benefit options for 2026 will remain the same as they were in 2025 with a small increase to the employee contributions for dental.

For further information please refer to the benefits section of this handbook or contact Human Resources.

Benefits for You & Your Family

Allied Interiors Group is pleased to announce our 2026 benefits program, which is designed to help you stay healthy, feel secure, and maintain a work/life balance. Offering a competitive benefits package is just one way we strive to provide our employees with a rewarding workplace. Please read the information provided in this guide carefully. For full details about our plans, please refer to the summary plans. Click here for additional information: **Plan Information.**

You may also go to this website: https://alliedinteriors.benefitsinfo.com

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Listed below are the Allied Interiors Group benefits available during open enrollment and qualifying life events:

- Medical
- Dental
- Vision
- Life and AD&D
- Voluntary Life
- Critical illness
- Hospitalization
- Accident

Who is Eligible?

All full-time employees working at least 30 hours per week and their eligible dependents may participate in the Allied Interiors Group benefits program.

Generally, for the Allied Interiors Group benefits program, dependents are defined as:

- Your legal spouse
- Dependent “child: up to age 26. (Child means the employee’s natural child or adopted child and any other child as defined in the certificate of coverage)

When and How Do I Enroll?

Current Employees who have satisfied the waiting period should log into ADP from November 9- 22 to make changes.

If no changes are made to MEDICAL, DENTAL, VISION AND ANCILLARY benefits, they will transfer to the new plan year.

You are REQUIRED to update your FSA Medical and FSA Dependent Care election if you wish to continue in 2026.

Enrollment for new hires is available during the first 30 days of employment.

When is My Coverage Effective?

If you are a current employee and have satisfied your waiting period, the effective date for your benefits is 01/01/2026.

Benefits for eligible new hires are effective on the 1st of the month following 30 days of continuous employment with Allied Interiors Group. See Human Resources for the enrollment materials.

Changing Coverage During the Year

You can change your coverage during the year when you experience a qualified change in status, such as marriage, divorce, birth, adoption, placement for adoption, or loss of coverage. The change must be reported to the Human Resource Department within 30 days of the event. The change must be consistent with the event.

For example, if your dependent child no longer meets eligibility requirements, you can drop coverage only for that dependent.

Medical Insurance

Allied Interiors Group will continue to offer medical coverage. The charts on the following pages are brief outlines of the plan. Please refer to the summary plan description for complete plan details. Click here for Medical Information**: Medical Information**. You may also go to this website**: https://curative.com/get-care**

The Medical Benefits Overview is on the next pages. One chart is for Baseline Compliant, and the second chart is for Baseline Non-Compliant. An important part of understanding the plan options is understanding that if you complete the Baseline visit your benefits are significantly better.

CURATIVE BASELINE Q&A

A Curative Baseline Visit is a personalized healthcare meeting that helps members of Curative's health plan get the most out of their membership. The visit includes: Onboarding, Health Assessment, Goal Setting, and Preventive Care Plan. It is a key part of Curative's preventive care approach and must be completed within the **first 120 days** of the plan start date.

Please Note: Even if you completed your Baseline visit in 2025 you must complete it again for 2026.

QUESTION	answer
How long does a Baseline Visit typically last?	- 45 minutes to 1 hour
What do I need to bring to my Baseline Visit?	- Your questions about your Curative Plan - Health goals and concerns. - You will need your Curative ID card, Date of Birth, and SS number.
What is Curative doing with the data collected during my Baseline visit?	- Data collected will not affect rates or premiums - Data will be kept confidential and not shared with any third party including Allied Interiors Group Data will be used by Curative to improve member experience
What is involved in a virtual Baseline visit?	- Virtual does not collect blood pressure, lab work, weight measurements or offer vaccines - Virtual will review medical history and make age-appropriate wellness and preventive recommendations
What clinical aspects are included in the Baseline Visit?	- Discuss any health questions or concerns that you, the member, may have - Discuss current and past medical history to connect you with the appropriate care and resources - Answers to questions asked are optional and will not affect eligibility to participate in the plan
How do I schedule a Baseline Visit?	- Online: https://health.curative.com/ - Member Services: (855) 4-CURATIVE (855) 428-7284 - Group Name: Allied Stone - Member Name, DOB, SSN
What if I do not do the Baseline?	- After 120 days you will no longer be eligible for the Cash Card benefits and your Cash Card will be deactivated. - Your current medical ID card will be voided and a new ID card with deductible and out of pocket expenses will be issued.

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Let's check back in

Another year, another Baseline

Complete your annual Baseline to continue with $0 care!

If you completed your Baseline last year, enjoy $0 care and preferred prescriptions straight away!*

If you missed last year's Baseline, you have a chance this time around to unlock your $0 perks.

Just remember to complete your Baseline **within 120 days of your plan renewal date** to keep or get these benefits.

As always, your Baseline is confidential and won't impact your premiums.

To schedule:

Log into your Curative account

You likely already have access to the member portal at health.curative.com. Log-in with your credentials or check and sign-up for your annual Baseline with the options below!

Part 1

Baseline Onboarding

Learn about your plan's benefits and resources, any updates and changes, find $0 providers, sign up for telehealth, check medication coverage, and get connected to programs to reach your health goals. For renewals, your onboarding will be self-guided.

Self-Guided Onboarding
Complete your onboarding on your own by watching short videos and completing important tasks. Your Care Navigator will follow up with you after to answer any questions.

Part 2

Baseline Clinical Check-in

Schedule a Zoom virtual meeting with a Curative Clinician to discuss your medical history and any health questions. They'll help create a plan tailored to you. You can even get labs done before or after for a more complete picture of your health. Austin residents can also schedule in-person.

Clinical Check-ins can be scheduled after the Self-guided Onboarding.

Done

Continue to enjoy $0 out-of-pocket costs!

Your Care Navigator will follow-up after the visit and you can always find their contact info on the Member Portal. For time-sensitive Curative benefit questions, you can call our **24/7 Member Services at 855-428-7284**.

Visit to learn more about the Baseline curative.com/baseline.

Watch to learn more about your Baseline Onboarding options. cur.tv/baseline-preview.

Who has to complete the annual Baseline Visit?

All our members must complete an annual Baseline Visit.
If you've joined us within the last 8 months before your renewal, don't worry – you won't have to go through the Baseline again right away. We've got your back until the next plan renewal.

If you're under 18 when your plan kicks in, you can hold off on the Baseline until the next plan year.

If you were moved to the high-deductible plan, you won't be shifted to the $0 out-of-pocket plan until after your renewal date and once your Baseline within the first 120 days of the renewal year is completed.

Members must complete a Baseline Visit within the first 120 days of the plan's start date to maintain $0 out-of-pocket costs for covered services with in-network providers and preferred prescriptions. EPO Value members must also use a Curative Pass for $0 covered care. See Summary Plan Description and Benefits Booklet for additional requirements for the Baseline Visit.

Allied Interior Group

Medical Benefits

2026 Baseline Due Before: 5/1/2026

New Hire Baseline Due Before: 120 days after eligibility date.

* Benefits are contingent upon employees completing their Baseline requirement with 120 days of plan effective date

The Medical Benefits Overview is on the next 2 pages. One chart is for Baseline Compliant, and the second chart is for Baseline Non-Compliant. An important part of understanding the plan options is understanding that if you complete the Baseline visit your benefits are significantly better.

Please Note: Even if you completed your Baseline visit in 2025 you must complete it again for 2026.

Allied Interiors Group

Medical Plans

BENEFIT OUTLINE AND COST SUMMARY

January 1, 2026 to December 31, 2026

Open Enrollment Baseline Due Before: 5/1/2026

* Benefit cost is contingent upon employee completing their Baseline requirement within 120 days of plan effective date

New Hire Baseline Due Before: 120 days after eligibility date

Benefit Details Description	Baseline Completed All Plans (EPO, PPO, PPO Max) In-Network Coverage*	Baseline Completed (EPO) Out of Network Coverage*	Baseline Completed (PPO) Out of Network Coverage*	Baseline Completed (PPO Max) Out of Network Coverage*
Carrier	Curative	Curative	Curative	Curative
Plan Type, Name, Network	Medical Baseline	Medical EPO	Medical PPO	Medical PPO Max
Deductible (Individual / Family)	$0	Not Covered	$10,000 / $20,000	$5,000 / $10,000
Out-of-Pocket Maximum (Individual / Family	$0	Not Covered	$15,000 / $30,000	$7,500 / $15,000
Wellness Exams (Routine Physicials)	$0 Copay / No Deductible	Not Covered	Out of Network: $50 Copay Required Immunization for Children under 6 yrs of age - No Copay	Out of Network: $50 Copay Required Immunization for Children under 6 yrs of age - No Copay
Primary Care Office Visit	$0 Copay / No Deductible	Not Covered	Out of Network: $50 Copay after Deductible	Out of Network: $50 Copay after Deductible
Specialist Office Visit	$0 Copay / No Deductible	Not Covered	Out of Network: $100 Copay after Deductible	Out of Network: $100 Copay after Deductible
Telemedicine - Urgent Care with a 24/7/365 On Demand Doctor's Visit	$0 Copay / No Deductible	Not Covered	Out of Network: Not Covered	Out of Network: Not Covered
Urgent Care Visit	$0 Copay / No Deductible	Not Covered	Out of Network: Plan pays 50% of allowable after deductible	Out of Network: Plan pays 80% of allowable after deductible
Emergency Room	$0 Copay / No Deductible	Not Covered	Out of Network: Plan pays 80% of allowable after deductible	Out of Network: Plan pays 80% of allowable after deductible
Outpatient Lab / X-Ray	$0 Copay / No Deductible	Not Covered	Out of Network: Plan pays 50% of allowable after deductible	Out of Network: Plan pays 80% of allowable after deductible
Complex Imaging (MRI, CAT, PET, et al.)	$0 Copay / No Deductible	Not Covered	Out of Network: Plan pays 50% of allowable after deductible	Out of Network: Plan pays 80% of allowable after deductible
Outpatient Surgical Facility	$0 Copay / No Deductible	Not Covered	Out of Network: Plan pays 50% of allowable after deductible	Out of Network: Plan pays 80% of allowable after deductible
Inpatient Hospital Facility	$0 Copay / No Deductible	Not Covered	Out of Network: Plan pays 50% of allowable after deductible	Out of Network: Plan pays 80% of allowable after deductible
Preferred Drugs, Generic, Brand and Specialty Drugs	$0 Copay / No Deductible	Not Covered	Out of Network: Plan pays 50% of allowable after deductible	Out of Network: Plan pays 80% of allowable after deductible
Non Preferred Brand/Generic Drugs	$50 Copay	Not Covered	Out of Network: Plan pays 50% of allowable after deductible	Out of Network: Plan pays 80% of allowable after deductible
Non Preferred Specialty Drugs	$250 Copay	Not Covered	Out of Network: Plan pays 50% of allowable after deductible	Out of Network: Plan pays 75% of allowable after deductible
Chiropractic Care	EPO – Not Covered PPO/PPO Max - $0 Copay (limit of 20 visits per year)	Not Covered	$50 Copay (limited to 20 visits per year)	$0 Copay (limited to 20 visits per year)

Allied Interiors Group

Medical Plans

BENEFIT OUTLINE AND COST SUMMARY

January 1, 2026 to December 31, 2026

Open Enrollment Baseline Due Before: 5/1/2026

*Benefit cost is for employees who did not complete their Baseline requirement within 120 days of plan effective date

New Hire Baseline Due Before: 120 days after eligibility date

Benefit Details Description	Baseline Not Completed (EPO) In/out of Network Coverage*	Baseline Not Completed (PPO) In/out of Network Coverage*	Baseline Not Completed (PPO Max) In/out of Network Coverage*
Carrier	Curative	Curative	Curative
Plan Type, Name, Network	Medical EPO	Medical PPO	Medical PPO Max
Deductible (Individual / Family)	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000
Non-Network Deductible (Individual / Family)	Not Covered	$10,000 / $20,000	$5,000 / $10,000
Out-of-Pocket Maximum (Individual / Family)	$7,500 / $15,000	$7,500 / $15,000	$7,500 / $15,000
Non-Network OOP Max (Individual / Family)	Not Covered	$15,000 / $30,000	$7,500 / $15,000
Wellness Exams (Routine Physicials)	In Network: No Copay	In Network: No Copay Out of Network: $50 Copay	In Network: No Copay Out of Network: $50 Copay
Primary Care Office Visit	In Network: $25 Copay after Deductible	In Network: $25 Copay after Deductible Out of Network: $50 Copay after Deductible	In Network: $25 Copay after Deductible Out of Network: $50 Copay after Deductible
Specialist Office Visit	In Network: $50 Copay after Deductible	In Network: $50 Copay after Deductible Out of Network: $100 Copay after Deductible	In Network: $50 Copay after Deductible Out of Network: $100 Copay after Deductible
Telemedicine - Urgent Care with a 24/7/365 On Demand Doctor's Visit	In Network: No Copay	In Network: $0 Out of Network: Not Covered	In Network: $0 Out of Network: Not Covered
Urgent Care Visit	In Network: Plan pays 80% of allowable after deductible	In Network: Plan pays 80% of allowable after deductible Out of Network: Plan pays 50% of allowable after deductible	In Network and Out of Network: Plan pays 80% of allowable after deductible
Emergency Room	In Network: Plan pays 80% of allowable after deductible	In Network and Out of Network: Plan pays 80% of allowable after deductible	In Network and Out of Network: Plan pays 80% of allowable after deductible
Outpatient Lab / X-Ray	In Network: Plan pays 80% of allowable after deductible	In Network: Plan pays 80% of allowable after deductible Out of Network: Plan Pays 50% of allowable after deductible	In Network and Out of Network: Plan pays 80% of allowable after deductible
Complex Imaging (MRI, CAT, PET, et al.)	In Network: Plan pays 80% of allowable after deductible	In Network: Plan pays 80% of allowable after deductible Out of Network: Plan pays 50% of allowable after deductible	In Network and Out of Network: Plan pays 80% of allowable after deductible
Outpatient Surgical Facility	In Network: Plan pays 80% of allowable after deductible	In Network: Plan pays 80% of allowable after deductible Out of Network: Plan pays 50% of allowable after deductible	In Network and Out of Network: Plan pays 80% of allowable after deductible
Inpatient Hospital Facility	In Network: Plan pays 80% of allowable after deductible	In Network: Plan pays 80% of allowable after deductible Out of Network: Plan pays 50% of allowable after deductible	In Network and Out of Network: Plan pays 80% of allowable after deductible
Preferred Drugs, Generic, Brand and Speciality Drugs	In Network: $50 Copay after Deductible	In Network: $50 Copay after deductible Out of Network: Plan pays 50% of allowable after deductible	In Network: $50 Copay after deductible Out of Network: Plan pays 80% of allowable after deductible
Non Preferred Brand and Generic Drugs	In Network; $100 Copay after Deductible	In Network: $100 copay after deductible for brand and generic. Out of Network: Plan pays 50% of allowable after deductible	In Network: $100 copay after deductible for brand and generic. Out of Network: Plan pays 80% of allowable after deductible
Non Preferred Specialty Drugs	In Network: Plan pays 75% of allowable after deductible	In Network: Plan pays 75% of allowable after deductible Out of Network: Plan pays 50% of allowable after deductible	In Network and Out of Network: Plan pays 75% of allowable after deductible
Chiropractic Care	Not Covered	In Network: $25 Copay Out of Network: $50 Copay (limited to 20 visits per year)	In Network: $25 Copay Out of Network: $25 Copay (limited to 20 visits per year)

Employee Contributions for Medical Plan

Employee Bi-Weekly Contributions (26 pay periods per year)	
EPO	
Employee	$75.23
Employee & Spouse	$275.03
Employee & Child(ren)	$181.94
Employee & Spouse & Child(ren) (Family)	$474.95
PPO	
Employee	$150.83
Employee & Spouse	$447.45
Employee & Child(ren)	$326.66
Employee & Spouse & Child(ren) (Family)	$706.87
PPO MAX	
Employee	$263.55
Employee & Spouse	$694.55
Employee & Child(ren)	$531.08
Employee & Spouse & Child(ren) (Family)	$1,045.61

Check to see if your doctor/ provider is in Network at this website:
Find Care: Find Doctors You Can Trust | Curative
https://curative.com/providers

You can obtain information about your medication at this website:
Find Pharmacy and Medication information | Curative
https://curative.com/drugs

curative cash card

Your Ticket to Hassle-free Care

We guarantee $0 copays and deductibles for any doctor in our search.* There are two options to provide payment covered by Curative:

1) insurance billing using the Curative Member ID Card

2) self-pay using our unique Curative Cash Card.

Either way, you don't pay.

What will be approved?

It can be used for:

- Primary care and office visits
- Urgent care
- Behavioral health
- Many inpatient and outpatient hospital services, such as imaging, surgeries, or medical monitoring.

What will not be approved?

Prescriptions, certain lab services, non-covered benefits

Questions?

Call Member Services, available 24/7 at 855-428-7284

***For EPO Value Members:** The Curative Cash Card gives you access to $0 care at any provider labeled "Curative Cash Card Only" that you have a Curative Pass for instead of your Member ID card. It can be used as a backup when you have a Curative Pass but your provider doesn't take your Member ID card.

To maintain $0 copays and deductibles, a Baseline Visit must be completed within the first 120 days of plan activation. Curative Cash Card Visa® Commercial Credit cards are issued by Celtic Bank. Additional Terms & Conditions can be found in your Member Portal

Here's how you can access your Curative Cash Card:

Step 1

Activate your Curative Cash Card by logging into the Member Portal at health.curative.com and selecting "Cash Card." Once activated, you'll instantly have access to your digital card.

A physical Cash Card will be delivered soon after your plan start date.

Note: Curative members must be 18 or older to access the card.

Step 2

Before attempting to use the Curative Cash Card, please try using your Curative Member ID Card first.

Step 3

If listed as Curative Cash Card only in the Provider Search, use your Curative Cash Card instead of your Member ID Card. Tell the front desk you will "pay cash!" and hand over your Curative Cash Card.

Backup: If a provider appears in our search but does not take your Member ID Card for any reason or tries to charge a copay, say you'll self-pay instead and hand over your Curative Cash Card.

CURATIVE CASH CARD Q&A

For Curative members only. A ticket to get in-network healthcare where and when you need it. As the fresh face in health plans, Curative recognizes that some doctors might not recognize Curative as a medical provider just yet. This card takes care of members' in-network costs for providers listed in the Curative directory.

QUESTION	answer
What is a Curative Cash Card?	- This card is specifically designed to put members' minds at ease, providing an immediate form of payment for in-network healthcare services. This is the same card as the ZERO card, with a new name.
Who is eligible for this card?	- Eligible members 18 years and older
Can these cards be used for dependent's permitted services?	- Yes, as long as services are covered, and the dependents are on the plan
Can members use this card for prescriptions or other health-related expenses?	- No, the card is currently setup to pay for office visits, urgent care visits, and some out-patient visits
Can members use the card at any time?	- Members can use it during the first 120 days. Members who complete the Baseline can use it for the full plan year - **The Cash Card will be deactivated after 120 days if Baseline is not completed** - Daily Maximum of $500 allowable charges per card/member for eligible in-network services
Can the Curative Cash Card be added to my digital wallet?	- Yes: Google Pay, Apple Wallet
How do I activate my Cash Card?	- Card can be activated through member portal https://health.curative.com/ - Member services at 1-855-4-CURATIVE - Group Name: Allied Interiors Group - Member Name, DOB, SSN

To nominate a provider to be a Cash Card Provider follow this link or QR code

Cash Card

For Curative members only. A ticket to get in-network healthcare where and when you need it. As the fresh face in health plans, Curative recognizes that some doctors might not recognize Curative as a medical provider just yet. This card takes care of members' in-network costs for providers listed in the Curative directory.

USING YOUR PLAN WISELY!

Becoming A Better Healthcare Consumer Under The Curative Plan

To keep our premiums competitive each year, it's important that we utilize Curative's $0 features appropriately.

- ✓ Value of your Baseline Visit – Complete again 2026
- ✓ Know where to go for care
  - Least expensive vs Most expensive
- ✓ Properly managing current conditions and lifestyle choices
  - Getting yourself healthier allows you to need the doctor less
  - Less time away from work and home
  - Follow through with baseline recommendations
  - Get your ANNUAL physical completed – Know your numbers!
- ✓ Get your annual physical with your Primary Care Provider
- ✓ "Shop" around for certain procedures
- ✓ Review all materials sent out by Allied Interiors Group and Curative`

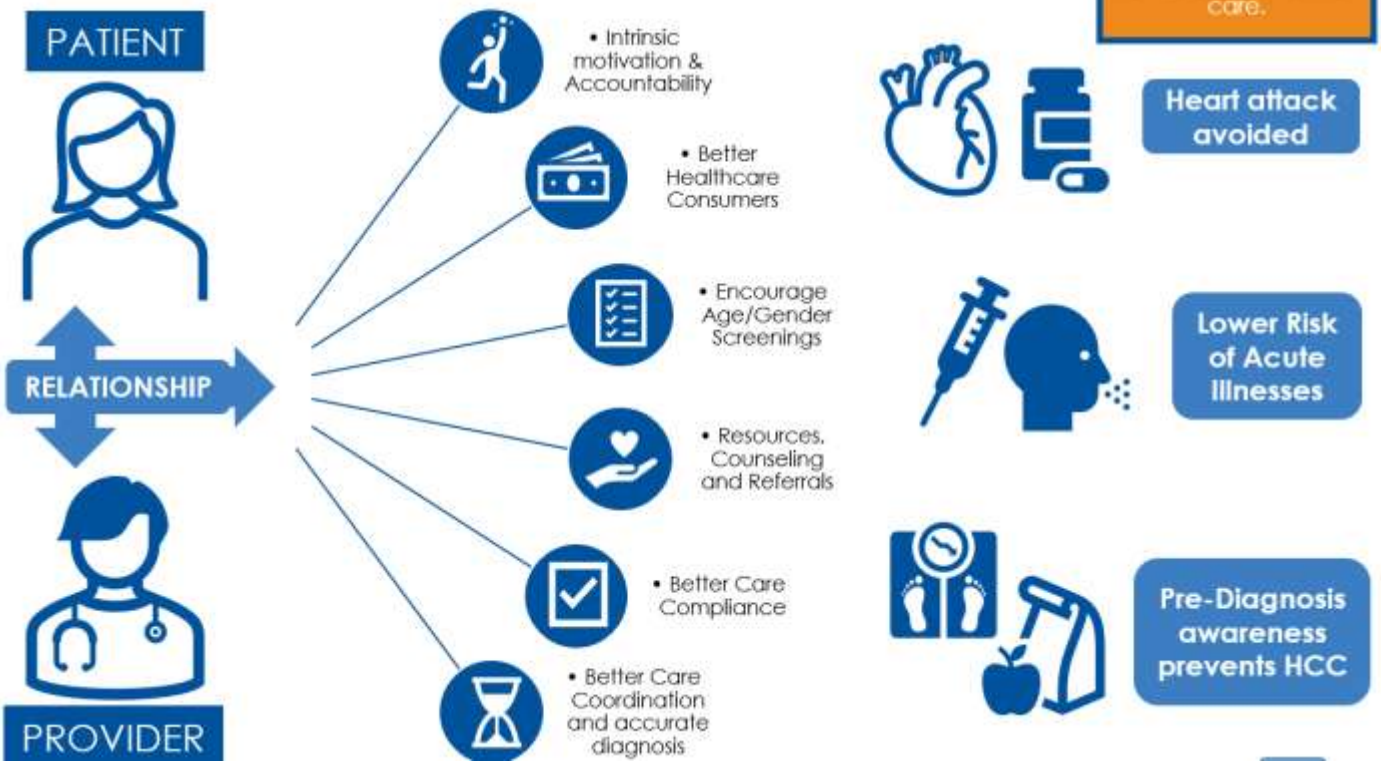
Care Center	Main Purpose	Type of Care	Cost and Time
Telehealth	• Speak with a doctor via phone or computer – from anywhere! 24/7/365 care access. • Doctor will diagnose the issue virtually and can write a prescription, if necessary. • It's the weekend, after hours or you just don't have time to see your doctor in the office • Your condition is not urgent or an emergency	• Minor illnesses • Minor infections • Cold and flu symptoms • Bronchitis • Allergies • Pink eye and other infections • And more!	• Available 24/7, from anywhere! • Quick appointment booking, within minutes • Minimal wait time $ *Learn more about Telehealth*
Doctor's Office	• Provide care or treatment of a wide range of health issues • Speak with your doctor within traditional office hours. • Your primary care doctor knows you and your health history, can access your medical records, and manage your medications	• Free Preventive Care, when in-network. • Routine checkups • Immunizations • General health management • Specialist referral	• Available during office hours. Some may offer virtual visits • Normally requires scheduling an appointment in advanced • Wait times will vary $$
Urgent Care	• Treatment of non-life-threatening injuries or illnesses by Physicians. • You may need care quickly, but it is not an emergency • It's the weekend, after hours and your primary care doctor is not available	• Minor Sprains or Strains • Minor broken bones (e.g., finger) • Minor infections • Minor cuts or burns • Vomiting • Diarrhea	• Generally open night and weekends; some open 24/7 • Walk-ins welcomed • Waiting times may vary $$$
Emergency Room	The ER is for the treatment of life-threatening or very serious conditions that require immediate medical attention. Do not ignore an emergency. If a situation seems life-threatening, take immediate action. **Call 911 or your local emergency number.**	• Uncontrollable bleeding • Chest pain • Head injury/Seizures • Difficulty breathing • Major broken bones • Major burns • Severe abdominal pain	• Open 24/7 • Walk-ins welcomed • Waiting times widely vary. *Life-threatening emergencies are treated first.* $$$$

Why is Wellness Important?

Encouraging appropriate health plan utilization can often enhance health literacy and an increased value perception of their benefits program.

KEY TAKEAWAY

Establishing a patient-provider relationship results in lower health plan costs by exchanging higher cost reactive care for lower cost preventive care.



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Medications made simple.

Preferred	Non-Preferred
Consists of generic and select brand and specialty medications	Consists of lower value generics, brands, and specialty medications
$0 Copay*	**$50 / $250 Copay***

Download our preferred drug list to see what's covered.

Use the preferred in-network pharmacies, including Curative, H-E-B, Albertsons, Amigos, Carrs, Haggen, Jewel-Osco, Market Street, MedCart, Pavilions, Randalls, Safeway, Sav-on, Tom Thumb, United, Vons, Publix, Brookshire Brothers, Publix.

For Curative members only, next-day pharmacy delivery to your home or work. Personalize services and rapid delivery available in most states.

*Every Curative member can qualify for the $0 deductible or copay for in-network care and preferred prescriptions. Just complete your Baseline Visit within 120 days of your plan's effective date. See curative.com to learn more. Curative Insurance Company.

Curative Pharmacy

See what's covered, make prescription transfers, and find updates on Curative Pharmacy's expansion at curative.com/pharmacy

Questions? Call Member Services at **855-428-7284 (855-4-CURATIVE)** for more information.

You can obtain information about your medication at this website:
Find Pharmacy and Medication information | Curative
https://curative.com/drugs

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Redefining Pharmacy, the Curative Way

We made our own Curative Pharmacy simple. Serving only Curative members, we're the overly attentive partner in health members never knew you needed.

Next Day Delivery
Next-day delivery available in most states and actively working to add the remaining.

Flexible Delivery Points:
Home, workplace, or wherever a member might be.

Two-Way Text Capabilities:
Members can communicate directly with our pharmacy about new medications, or refills.

Making it Simple
Curative Pharmacy will work with doctors, previous pharmacies and anyone in between to make sure members are covered every step of the way.

Regular Check-ins:
We stay in touch and make sure medications are going well.

One-Stop-Shop
Members with multiple medications can be serviced by one easy-to-use pharmacy.

Trusted Tips
We know the cost-effective choices to help members make the most of their benefits.

Members can sign-up 24/7/365 for the Curative Pharmacy through member services: 855-4-CURATIVE.

**Every Curative member can qualify for the $0 deductible or copay for in-network care. Just complete a Baseline Visit in your first 120 days. See curative.com to learn more. Curative Insurance Company PPO.BR230921-1*

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Bending the **cost curve** and improving **employee wellbeing** with **member engagement**

Curative is removing barriers to care with affordability, engagement, and simplicity. When members actually use their benefits we **improve health outcomes** and lower costs.

Current health care isn't working for anyone

Rising deductibles and copays mean people are deferring care. Even a basic visit to a doctor can come with a lot of out-of-pocket expenses. Plus, the system is so complex and with nobody to help, getting the right care can be overwhelming. So we defer care as long as we possibly can, and prescriptions go unfilled because they're simply unaffordable.

Transparent, next-generation health care employees will love to use

We've created a simple plan that consumers love to use—that removes cost barriers like copays, deductibles and most prescription charges, while providing trusted support at every step— we will completely change the way members engage with their health. Getting every member the preventive care they need, encouraging healthy behaviors, putting medical advancements to work, and helping us all live longer, healthier lives — with lower long-term total costs of care for members and employers alike.

Curative Care Navigators

Care Navigators are at the core of our member-centric experience. Each Curative plan member is paired with a Care Navigator who will be their **first point of contact** to onboard with our plan, and support them through their entire journey as a member, providing resources and guidance on maximizing their **Curative benefits** to reach their health goals.

> Most people do not choose to seek the care that they need because of small barriers to access – not knowing the right questions to ask or lack of awareness of the resources available to them. I am easily accessible by phone, text, or email and the members can reach out to me directly at any time. It is my hope that I will build a relationship with the members during their **Baseline Visits** so that they feel comfortable enough to ask any questions that they may have about seeking care.
>
> -Kyra N., Care Navigator

Let's partner up for **healthier employees**, and **healthier bottom lines** https://curative.com

Engagement from the start

In order to qualify for **$0 copays and deductibles** members must complete a Baseline Visit within the first 120 days of the plan effective date.

98% of health plan participants complete the Baseline Visit)

The **Baseline Visit**

A Baseline Visit is an **individualized virtual appointment** with a **Care Navigator** that focuses on the member's complete well-being and shares how to best utilize **Curative benefits** and resources.

Proactively starting the conversation around **health goals** and providing the tools to achieve them sets your employees up for **long-term success** and improved satisfaction.

Members also meet with a clinician who will review medical history, help the member with a care plan and, if appropriate, connect them to Curative **wellness management programs** for chronic or acute conditions related to: obesity, hypertension, diabetes, and maternal health. We also have a **robust case management** process to help with acute situations.

Continued member support so employees can focus on what matters

We've created a simple plan that consumers love to use—that removes cost barriers like copays, deductibles and most prescription charges, while providing trusted support at every step— we will completely change the way members engage with their health. Getting every member the preventive care they need, encouraging healthy behaviors, putting medical advancements to work, and helping us all live longer, healthier lives — with lower long-term total costs of care for members and employers alike.

Better health benefits benefit your business

Employers should offer plan options that focus on high-quality, comprehensive coverage that is cost-transparent, member-centric, and encouraged to use. When members are equipped and incentivized to prioritize their health, their health, wellbeing, and productivity improves.

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Elevate Your Workforce with Curative Member Services:

At Curative, we've **revolutionized** the way our member services interact, providing a **simple, in-house and interactive experience** that puts **employees' health in their own hands.**

A High-Touch, Personalized Approach:	Enhanced Provider & Pharmacy Selection:	Empowering Employees with Online Tools:	24/7 Member Services at Your Fingertips:	Streamlined Prescription Management:
Say goodbye to impersonal interactions and hello to a designated Care Navigator for each member, providing personalized support every step of the way.	Whether it's finding an in-network specialist or locating a nearby participating pharmacy, we can make the process simple and stress-free	From log-in access to helping update contact information and scheduling appointments, we provide assistance navigating our user-friendly member portal	Health concerns can arise at any time. That's why we are available 24/7/365 to help members with coverage questions. **If you are experiencing a medical emergency dial 911 or go to your nearest emergency center*	Transferring prescriptions and verifying coverage can be a hassle; we are here to alleviate that burden, whether it's checking if a specific medication is covered or understanding tier levels.

Care Navigators vs Member Services

Care Navigators
At the Baseline Visit, members receive a Care Navigator, their go-to source for all things Curative, and the direct point of contact if there are questions or concerns about coverage.

Member Services
Members can access our Member Services 24/7/365 for assistance. Our Member Services team is an excellent resource for any questions that may arise.

Member Services are available to assist with:

- Finding and verifying in-network providers
- Locating a participating pharmacy
- Transferring prescriptions
- Medication coverages & tiers
- Member Portal access and logging in
- Scheduling a Baseline Visit
- Updating member contact information
- Prior Authorizations
- Claims Processing and denial resolution

Say goodbye to frustrations and hello to a better healthcare experience, where employees are at the center of their own healthcare journey.

Available 24/7/365 | 855-428-7284 | health@curative.com

curative telehealth

Curative Telehealth: Fast, seamless virtual care

Get the care you need, anytime, anywhere.

Curative Telehealth provides 24/7 nationwide virtual care, connecting you with a licensed provider in less than 7 minutes. Whether by phone or video, get fast, hassle-free care—directly through your Curative Member Portal.*

- **Fast, easy access**
  See a provider **in minutes,** anytime, from home, work, or on the go.
- **Seamless experience**
  Access directly through your Curative Member Portal without the hassle of extra apps or logins.
- **Nationwide coverage**
  Available **in all 50 states**, so you always have a consistent virtual care option.
- **Online or phone**
  Select **video or phone** visits based on your needs and comfort level.
- **Guided symptom intake**
  Answer a few quick questions to get connected with the right care provider.

Getting started with Curative Telehealth is easy

1. **Log in or call**
   Start a visit through your Curative member portal or by phone.
   health.curative.com/curative-telehealth
2. **Answer a few questions**
   Our system will match you with the right provider.
3. **See a provider fast**
   Get care via **video or phone,** with visits starting **in less than 7 minutes.**

For more info, go to curative.com/telehealth

*For EPO Value, no Curative Pass is required for Curative Telehealth.

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Curative Guide to $0 Care*

Two cards. One goal. Zero dollars.

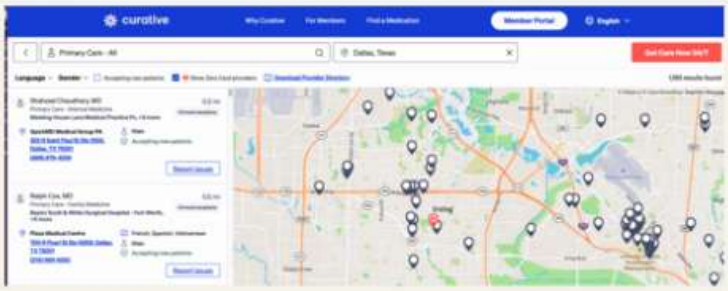
We guarantee $0 copays and deductibles for covered services provided by any doctor in our search.* There are two options to provide payment covered by Curative: 1) insurance billing using the Curative Member ID Card and 2) self-pay using our unique **Curative Cash Card**.

Either way, you don't pay. Here is a quick and easy guide to $0 care.

Start here

Provider Search

All clinicians shown at curative.com/providers have $0 out-of-pocket costs for covered services.



Option 1

Member ID Card

Use the Curative Member ID Card first if the provider shows in our search.

Option 2

Curative Cash Card

Use the Curative Cash Card for any provider that shows as Curative Cash Card. Tell the front desk you will **self-pay** and hand over your Curative Cash Card. Think of it as a payment card with no impact on credit. It can be used for office visits, urgent care, behavioral health, and certain services without hospital stays. It does not include medications, labs and non-covered benefits.

More $0 Providers: It's easy to nominate a provider for the Curative Cash Card. Fill out a quick form cur.tv/nominate or call Member Services 855-428-7284.

Backup: If a provider appears in our search but does not take your Member ID Card for any reason or tries to charge a copay, say you'll self-pay instead and hand over your Curative Cash Card.

Members must be 18 years and older to use the Curative Cash Card and complete their Baseline Visit in the first 120 days of their plan start date to maintain $0 out-of-pocket costs. Curative Cash Card Visa® Commercial Credit cards are issued by Celtic Bank. Additional Terms & Conditions can be found in your Member Portal Account at health.curative.com.

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Where mental health support isn't a perk – it's the plan.

While most plans fall short on behavioral health, Curative closes the gap. We combine broad in-network access, leading virtual partnerships, and cash-pay flexibility—so every member can get the care they need, with $0 cost-sharing and no red tape.

Unmatched mental health benefits:

Expansive mental health options: Members get $0 access to therapy, psychiatry, and condition-specific support through partners like Rula and Two Chairs—plus in-network providers across the country. Curative removes waitlists and cost barriers to connect members to the right care, fast.

Substance use management: Curative covers personalized, stigma-free care through Pelago, Recovery Unplugged and in-network providers—with virtual and in-patient options that cost $0 to the member.

Direct pay option: Nearly 1 in 3 mental health professionals don't take insurance. With Curative's payment card, members can see self-pay therapists and counselors—at no cost—bypassing outdated insurance barriers entirely.

Every Curative member can maintain access to **$0 deductibles and copays** for covered services – including therapy, psychaitry and preferred prescriptions—simply by completing a Baseline Visit within the first 120 days of their plan start date.

Members access $0 mental health care via in-network providers, virtual partners, and even self-pay providers using a Curative payment card.

Featured mental health providers

At Curative, we understand that supporting your employees' mental well-being is essential to maintaining a healthy, productive workforce. That's why we're committed to providing seamless access to reliable, supportive, and convenient mental health resources—so your team gets the care they need, when they need it. Members can also use our search tool to find local in-network options or apply their Curative card with eligible self-pay therapists—bypassing the limitations of traditional plans.

Provider	Condition	Ages	Availability	Cost with completion of the Baseline Visit
Rula	Individual, couples, and family therapy sessions (5+); psychiatry (13+)	5+, 13+	Virtual, Nationwide	$0
Two Chairs	Therapy matching & support	18+	Virtual (AZ, CA, CO, FL, IL, MI, MN, NJ, NY, OH, OR, PA, SC, TX, VA, WA); In-Patient in FL, CA, WA	$0
Televero	Virtual therapy, counseling, and psychiatry sessions	All	Virtual (Texas and Florida members)	$0
Pelago	Substance use and mental health disorders	All	Virtual, nationwide	$0
Recovery Unplugged	Substance use and mental health disorders	All	Virtual (TX, FL, VA, TN, SC, NJ); In-Patient in Fort Lauderdale, FL	$0

Why is this important?

Only 44% of employers believe their current plan offers enough in-network behavioral health options to meet the needs of their employees and their families. Curative eliminates financial barriers and expands culturally aligned, in-network access to care, ensuring members get timely, relatable support while helping employers reduce costs and improve workforce well-being.

Source: KFF

Explore our mental health resource options & learn more at curative.com/mental-health.

curative | Rula

$0 therapy and psychiatry

Your path to mental well-being starts with Rula.

Rula connects Curative members with more than **15,000 licensed therapists and psychiatrists** across the country. These services are available at **no cost to you**.* Therapy is available for **adults, children ages 5 and up, couples, and families**. Psychiatry services are offered for teens ages 13 and up, and adults.

Why choose Rula for your mental health needs?

Match with a provider in 30 seconds

Rula's platform connects you with a licensed provider almost instantly—typically in just 30 seconds.

Be seen as soon as 2 days

Once you're matched, you can schedule an appointment and be seen by your provider in as little as two days. Rula's efficient system is designed to deliver prompt care when you need it most.

Flexible virtual care offerings

Access a full range of virtual services, including individual, couples, and family therapy, plus psychiatric care.

Providers in all 50 states

Enjoy access to quality, in-network, virtual care from licensed providers available nationwide in all 50 states.

To start your path to better mental well-being, visit **rula.com/curative**.

*Rula's services will continue to be $0 for Curative members who complete their Baseline Visit within 120 days of their plan effective date. 251403

curative | Pelago

Stopping the stigma starts with you.

Curative has partnered with Pelago to help you or your family members take the first step towards cutting back, managing, or quitting use of alcohol, tobacco, or opioids. Just like diabetes or high blood pressure, addiction is a chronic condition that can be treated. People do get better, you or your family member could be one of them.

3 easy steps to sign up

01 Scan the QR code or visit pelago.health/curative

02 Download the Pelago app

03 Create an account (at no cost to you*)

We've got your back

Health goal tracking - Set your goal and join a tailored program to make real progress.

24/7 access - Check in and track your progress all from the privacy of your home via our mobile app.

1:1 personalized support - Your dedicated coach is with you every step of the way, when you want it.

Get to know Pelago.

Pelago is part of your Curative benefits, and our programs are available at no cost to you.* It's completely confidential and always judgment-free. Pelago has helped thousands of people quit or cut back on their substance use.

Questions?

Reach out to your Care Navigator or Member Services at 855-428-7284

Pelago is available to Curative plan members and their covered dependents ages 18 & up.

*Every Curative member can qualify for the $0 out-of-pocket costs for in-network care and preferred prescriptions with the completion of a Baseline Visit in the first 120 days of the plan effective date. See curative.com to learn more.

Additional Programs

Visit www.curative.com/programs for more details

- Mental Health
- Type 2 Diabetes
- Weight Management
- Galleri (50+)
- Substance Use
- Nutrition
- Hypertension
- Maternity

GET ACCESS TO THE BEST CARE

1. Curative Member Services: call or text 855-428-7284, 24/7/365
2. Email Member Services: health@curative.com
3. Go to www.curative.com to create your login.
4. Go to www.curative.com/get-care to utilize telehealth, search for in-network providers and pharmacies.
5. Click here to go to **Cash Card** or use the QR code below to nominate a provider.

The Core Plan

The Core Indemnity Plan is still available through the American Worker. No changes in employee contributions or benefits.

The American Worker Indemnity Plan Group #1609	
Benefit Coverage	**Standard Plan / PHCS Network**
Physician's Office	$50 per day, 6 days per year
Telemedicine (Healthiest You)	Free access to doctors by phone or online
Preventive Care	$100 per day, 1 day per year
Outpatient Diagnostic, Lab/ Xray	$25 per testing day, 2 days per year
Outpatient Advanced Studies	$100 per testing day, 3 days per year
Emergency Room	$100 per day, 2 days per year
Surgical In Patient	$500 per day, 1 day per year
Surgical Out Patient	$250 per day
Surgical Outpatient Minor	$50 per day
Surgical Outpatient Maximum	1 day per year
Anesthesia	30% of surgical benefit
Daily Hospital Indemity	$100 per day, 500 day, lifetime max
Hospital Admission	$100 lump sum per confinement
Intensive Care Unit	$200 Per day, 30 days per year
Substance Abuse/ Mental Illness	$50 Per day, 30 days per year
Skilled Nursing	$50 per day, 60 days per year
Ambulance (Ground and Air)	$100 Per day, 2 days per year
Accident Medical AD& D (employee / spouse / child)	Up to $5,000 per occurrence $15,000 / $7,500 / $3,000
Prescription Drugs	$10, $20, $50 Tier

Employee Contributions for Core Plan

Employee Monthly Contributions	
Indemnity Plan	
Employee	$28.91
Employee & Spouse	$61.69
Employee & Child(ren)	$46.89
Family	$66.30

Dental Insurance

Allied Interiors Group will continue to offer a dental program through Mutual of Omaha. The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details. Group Number G000CLHB

Benefit Coverage	Dental – Low Plan		Dental – High Plan	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Annual Deductible				
Individual	$50	$50	$50	$50
Family	$150	$150	$150	$150
Waived for Preventive Care?	Yes	Yes	Yes	Yes
Annual Maximum				
Per Person / Family	$1,000	$1,000	$2,000	$2,000
Preventive	100%	100%	100%	100%
Basic	80%	80%	80%	80%
Major	50%	50%	50%	50%
Orthodontia				
Benefit Percentage	Not covered	Not covered	50%	50%
Adults	Not covered	Not covered	Covered	Covered
Dependent Child(ren)	Not covered	Not covered	Covered	Covered
Lifetime Maximum	N/A	N/A	$2,000	$2,000

Employee Bi-Weekly Contributions (26 pay periods per year)	
Dental – Low	
Employee	$11.01
Employee & Spouse	$22.57
Employee & Child(ren)	$23.05
Family	$35.78
Dental High	
Employee	$23.60
Employee & Spouse	$48.40
Employee & Child(ren)	$49.40
Family	$76.76

Vision Insurance

Allied Interiors Group provides Vision Insurance through Mutual of Omaha. Summary of Benefits is below.

Benefit Coverage	Mutual of Omaha Insurance Company Group Number G000CLHB
Copay	
Routine Exams (Annual)	$10 copay
Vision Materials	
Materials Copay	$25 copay
Lenses	Benefit varies by type of lens. Covered every 12 months (contact lens or lens for glasses)
Contacts Covered in lieu of frames. Medically necessary contacts may be covered at a higher benefit level	Elective contacts covered 100% to up to $150 allowance; 15% discount off balance. Lens allowed every 12 months (contact lens or lens for glasses)
Frames	Covered at 100% up to $150 allowance; 20% discount off balance every 24 months

	Employee Bi-Weekly
Vision	
Employee	$2.76
Employee and Spouse	$6.37
Employee & Children	$6.74
Family	$10.68

Flexible Spending Account (FSA)

The Flexible Spending Account (FSA) plan with ***iSolved Benefit Services*** (previously known as Infinisource) allows you to set aside pre-tax dollars to cover qualified healthcare and dependent care expenses you would normally pay out of your pocket with post-tax dollars. You pay no federal or state income taxes on the money you place in an FSA. The 2025 allowed contribution limit is **$3,300**. (The allowed contribution for 2026 is increasing to $**3,400)**.

The FSA plan year is January 1st to December 31st each calendar year. You can participate in a Health Care FSA and/or the Dependent Care FSA**, but you MUST re-enroll in the FSA each plan year. Prior year elections will only let you carry over $680.**

Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a qualifying life event.

Plan	Full Healthcare FSA	Dependent Care FSA
Who is Eligible	For employees enrolled in any of the EPO/ PPO Medical plans or another non-HSA medical plan.	For all benefit eligible employees
Annual Limits	Contribute up to $3,400 per FSA Plan Year.	Contribute up to $7,500 per year, or $3,750 if married and filing separate tax returns.
Who is Covered	You, your spouse, and dependent children, even if not covered on your medical plan.	Dependent children under age 13 or any dependent claimed on federal income taxes who are incapable of self-care.
Eligible Expenses	Medical, dental or vision copays, coinsurance, deductibles, eyeglasses, and many over-the-counter medications.	Day care and after-school programs for dependents up to age 13 or day care for a tax-claimed dependent of any age. Care must be necessary for you and your spouse to work or attend school full-time.
Spend By	Carry-over up to $680 to the next plan year. Unused funds over this amount will be forfeited.	Any unused funds in your account after December 31st will be forfeited under the IRS “use-it-or-lose-it” rules.

How an FSA works:

- Choose a specific amount of money to contribute each pay period, pre-tax, to one or both accounts during the year.
- The amount is automatically deducted from your pay at the same level each pay period.
  - **You have immediate access to the full annual elected amount in your Healthcare FSA as of January 1st.**
  - **You will only be able to access available funds in your Dependent Care FSA, not “future” funds.**
- As you incur eligible expenses, you may use your flexible spending debit card to pay at the point of service OR submit the appropriate paperwork to be reimbursed by the plan.
- **Save your receipts! You may be required to produce them during a plan year audit as required by the IRS.**

Employee Assistance Program

Life isn't always easy. Sometimes a personal or professional issue can affect your work, health and general well-being. During these tough times, it's important to have someone to talk with to let you know you're not alone.

With Mutual of Omaha's Employee Assistance Program, you can get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker your employer counts on to get the job done.

Learn more about the Employee Assistance Program services available to you.

We are here for you

Visit the Employee Assistance Program website to view timely articles and resources on a variety of financial, well-being, behavioral and mental health topics.

mutualofomaha.com/eap
or call us: 1-800-316-2796

Enhanced EAP Services

Features	Value to Company and Employees
Employee Family Clinical Services	• An in-house team of Master's level EAP professionals who are available 24/7/365 to provide individual assessments • Outstanding customer service from a team dedicated to ongoing training and education in employee assistance matters • Access to subject matter experts in the field of EAP service delivery
Counseling Options	• Three sessions per year (per household) conducted by either face-to-face* counseling or video telehealth via a secure, HIPAA compliant portal
Exclusive Provider Network	• National network of more than 10,000 licensed clinical providers • Network continually expanding to meet customer needs • Flexibility to meet individual client/member needs

*California Residents: Knox-Keene Statute limits no more than three face-to-face sessions in a six-month period per person.

Continued on back.

Mutual of Omaha

Enhanced EAP Services *(continued)*

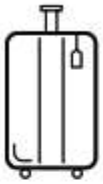
Features	Value to Company and Employees
Access	• 1-800 hotline with direct access to a Master's level EAP professional • 24/7/365 services available • Telephone support available in more than 120 languages • Online submission form available for EAP service requests • EAP professionals will help members develop a plan and identify resources to meet their individual needs
Employee Family Legal Services	• Valuable resources – legal libraries, tools and forms – available on EAP website • A counseling session may be substituted for one legal consultation (up to 30 minutes) with an attorney • 25% discount for ongoing legal services for same issue
Employee Family Financial Services	• Inclusive financial platform powered by Enrich that includes financial assessment tools, personalized courses, articles and resources, and ongoing progress reports to help members monitor their financial health • A counseling session may be substituted for one financial consultation (up to 30 minutes) with an attorney • 25% discount for ongoing financial services for same issue
Employee Family Work/Life Services	• Child care resources and referrals • Elder care resources and referrals

Online Services	• An inclusive website with resources and links for additional assistance, including:
	  • Current events and resources
	  • Family and relationships
	  • Emotional well-being
	  • Financial wellness
	  • Substance abuse and addiction
	  • Legal assistance
	  • Physical well-being
	  • Work and career
	• Bilingual article library

Employee Communication	• All materials available in English and Spanish
Eligibility	• Full-time employees and their immediate family members; including the employee, spouse and dependent children (unmarried and under 26) who reside with the employee
Coordination with Health Plan(s)	• EAP professionals will coordinate services with treatment resources/providers within the employee's health insurance network to provide counseling services covered by health insurance benefits, whenever possible

https://www.mutualofomaha.com/eap/

MUTUAL of OMAHA | Underwritten by Mutual of Omaha Insurance Company



Worldwide Travel Assistance and Identity Theft Protection for You and Your Family

Travel Assistance can help you avoid unexpected bumps in the road anywhere in the world. For you, your spouse and dependent children on any single trip up to 120 days in length, and more than 100 miles from home.

PRE-TRIP ASSISTANCE*

Minimize travel hassles by calling us pre-departure for:

- Information regarding passport and other documentation needs
- Travel, health advisories and inoculation requirements for foreign countries
- Daily foreign currency exchange rates
- Consulate and embassy locations

IMMEDIATE ATTENTION FOR EMERGENCIES WHILE TRAVELING

While traveling more than 100 miles from home, call Travel Assistance toll-free 24/7 for immediate help from a multi-lingual professional.

**Available at any time, not subject to 100 mile travel radius*

EMERGENCY TRAVEL SUPPORT SERVICES

- **Translation and interpreter services** – 24/7 access to translators or interpreters
- **Locating legal services** – referrals for local attorney or consular offices and help maintaining business and family communications until legal counsel is retained (includes coordination of financial assistance for bonds/bail)
- **Baggage** – assistance with lost, stolen or delayed baggage while traveling on a common carrier
- **Emergency payment and cash** – assistance with advance of funds for medical expenses or other travel emergencies by coordinating with your credit card company, bank, employer, or other sources of credit; includes arrangements for emergency cash from a friend, family member, business or credit card
- **Emergency messages** – assistance with recording and retrieving messages between you, your family and/or business associates at any time
- **Document replacement** – coordination of credit card, airline ticket, or other documentation replacement
- **Vehicle return** – if evacuation or repatriation is necessary

Fold Here

Worldwide Travel Assistance MUTUAL of OMAHA

Services available for business and personal travel.
For inquiries within the U.S. call toll free:
1-800-856-9947
Outside the U.S. call collect:
(312) 935-3658

CARRY THIS CARD WITH YOU WHEN YOU TRAVEL

Brought to you by Mutual of Omaha.
Travel Assistance Services provided
by AXA Assistance USA, Inc.

Fold Here

MEDICAL ASSISTANCE

- Locating medical providers and referrals
- Communication on your medical status with family, physicians, employer, travel company and consulate
- Emergency evacuation if adequate medical facilities are not available, including payment of covered expenses
- Transportation home for further treatment – in the event of death, assist in the return of mortal remains
- Transportation arrangements for the visit of a family member or friend if your hospitalization is more than seven calendar days
- Return home for dependent children if your hospitalization is more than seven calendar days
- Assistance with lodging arrangements if convalescence is needed prior to, or after, medical treatment
- Coordination with your health insurance carrier during a medical emergency
- Assistance obtaining prescription drugs or other necessary personal medical items

TRAVEL ASSISTANCE PLAN LIMITATIONS

AXA Assistance USA will not pay emergency evacuation, medically necessary repatriation, repatriation of remains or other expenses incurred while traveling within 100 miles of participant's place of residence, or for any one of the following reasons:

- Traveling against the advice of a physician
- Traveling for medical treatment
- Pregnancy and childbirth (exception: complications of pregnancy)

Expenses for emergency evacuation, medically necessary repatriation, repatriation of remains, return of dependent children, family or friend transportation arrangement and vehicle return are covered up to $200,000 per person per event.

IDENTITY THEFT

Your Travel Assistance benefit automatically includes Identity Theft Assistance, coordinated at no additional cost. Whether at home or traveling, this benefit provides education, prevention and recovery information to help you protect your identity.

EDUCATION AND PREVENTION

- Comprehensive ID theft assistance guide
- Tips to defend against ID theft

RECOVERY INFORMATION

- Information regarding the steps to recover from credit card and check fraud
- Guidelines if your Social Security number is compromised
- Instructions for lost or stolen passport
- Contact list for financial institutions, credit bureaus and check companies

ASSISTANCE

If you need help with an ID theft issue, case managers are available 24 hours a day, seven days a week and can be reached by calling the same toll-free number used to contact AXA: 800-856-9947.

Mutual Solutions

Will Preparation Services

Services provided by Epoq, Inc.

Create your will at www.willprepservices.com and use the code MUTUALWILLS to register

Creating a will is an important investment in your future. It specifies how you want your possessions to be distributed after you die.

Whether you're single, married, have children or are a grandparent, your will should be tailored for your life situation.

That's why it's good you have access to FREE online will preparation services provided by Epoq, Inc. (Epoq).

Easy, Free and Secure

Epoq offers a secure account space that allows you to prepare wills and other legal documents. Create a will that's tailored to your unique needs from the comforts of your own home.

Epoq provides the following FREE documents:

- Last Will and Testament
- Power of Attorney
- Healthcare Directive
- Living Trust

Here's how it works:

- Log on to www.willprepservices.com and use the code MUTUALWILLS to register
- Answer the simple questions and watch the customization of your document happen in real time
- Download, print and share any document instantly
- Don't forget to update your documents with any major life changes, including marriage, divorce, and birth of a child
- Make the document legally binding — Check with your state for requirements

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

Life and Accidental Death & Dismemberment

Allied Interiors Group provides Basic Life and AD&D benefits to eligible employees. The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan.

Mutual of Omaha Insurance Company Group Number G000CLHB	
You	
Benefit Maximum	$25,000
Guaranteed Issue	$25,000
Your Spouse	
Benefit Maximum	Not covered
Guaranteed Issue	Not covered
Your Child	
Benefit Maximum	Not covered
Guaranteed Issue	Not covered

The above benefits will begin to decrease at age 65. At age 65 benefits reduce to 65% of the original amount covered. At age 70 benefits reduce to 50% of the original amount covered.

Voluntary Life Offerings

In addition to the employer paid Basic Life and AD&D coverage, you have the option to purchase additional voluntary life insurance to cover any gaps in your existing coverage that may be a result of age reduction schedules, cost of living, existing financial obligations, etc. Your election, however, could be subject to medical questions and evidence of insurability. If you are a late entrant, an EOI form will be required.

Your contributions will depend on your age and the amount of coverage you elect. You (Employees) may elect 5 x your salary up to $100,000 without an Evidence of Insurability (EOI) form including medical questions. You may elect up to 5x your annual salary up to $300,000 however you must complete an EOI and it will be reviewed to determine if you are eliible for additional coverage. Your spouse may elect 100% of your benefit up to $15,000 without an EOI and children may elect $10,000 without an EOI. Your spouse may elect up 100% of the Employee's benefit up to $150,000, however, your spouse must complete an EOI and it will be reviewd to determine if you are eligible. Group Number G000CLHB.

Rates are determined by age. The age for the spouse and the employee are based on the age of the employee.

BENEFIT SUMMARY

Employee Benefit Amounts

Minimum Benefit	Maximum Benefit	Increments	Guarantee Issue Amount*
$10,000	5X Annual Salary, up to $300,000	$10,000	5X Annual Salary, up to $100,000

*Guarantee Issue Amounts assume a participation rate of at least 25% of eligible employees.

Benefit Reduction Schedule**

At Age	Benefits Reduce to:
65	65%
70+	50%

** All benefit reductions are a percentage of the original benefit amount. Coverage terminates at retirement. The Guarantee Issue Amount is reduced according to the reduction schedule.

Dependent Spouse Benefit Amounts***

Minimum Benefit	Maximum Benefit	Increments	Guarantee Issue Amount
$5,000	100% of Employee's Benefit, up to $150,000	$5,000	100% of Employee's Benefit, up to $15,000

*** Dependent Spouse and/or Child coverage is only available if the Employee has coverage under this plan. Spouse coverage terminates at age 70.

Dependent Child Benefit Amounts

Minimum Benefit	Maximum Benefit	Increments	Guarantee Issue Amount
$10,000	$10,000	$10,000	$10,000

Dependent child coverage from birth to six months is as follows:

Birth to 14 days	14 days to 6 mos.
$1,000	$1,000

AD&D Benefit Amount

The AD&D Principal Sum amount is equal to the amount of voluntary term life insurance for employees and eligible dependents.

Rates will be available in the ADP enrollment portal.
Benefits for the spouse end at age 70.

Worksite Products

Voluntary Accident & Injury

No one plans to have an accident, but it can happen at any moment throughout the day. Most major medical insurance plans only pay a portion of the bills. Our policy can help pick up where other insurance leaves off and provide cash to cover the expenses. Our accident coverage helps offer peace of mind when an accidental injury occurs. The Accident Plan coverage is extensive. Please see the full summary for the details. The summary is available via Human Resources. Only off the job injuries are covered.

If you broke a leg, would it break your bank account too?

Don't let an accident catch you off guard. Protect your family's finances with Accident Insurance from United of Omaha Life Insurance Company.

An accident insurance policy supplements your medical coverage and provides a cash benefit for injuries you or an insured family member sustain from an accident. This benefit can be used to pay out-of-pocket medical expenses, help supplement your daily living expenses and cover unpaid time off work.

As an active employee of Allied Stone, Inc., you may purchase this coverage for yourself and your family members, and premiums can be deducted from your paycheck. It's a simple and affordable way for your family to receive added financial protection.

Coverage guidelines and benefits are outlined below.

ACCIDENT BENEFITS

INITIAL CARE & EMERGENCY BENEFITS Most Initial Care/Emergency benefits require treatment or service within 72 hours of an accident and are payable once per accident per insured person.

Benefit	Amount
Initial Care	**Class 1**
Emergency Room	$300
Urgent Care Center	$225
Initial Physician Office Visit	$100
Emergency Transportation	**Class 1**
Ground Ambulance	$300
Air Ambulance	$1,500

ACCIDENT MONTHLY PREMIUM RATES

	Employee/Member	Employee/Member + Spouse	Employee/Member + Child(ren)	Employee/Member + Family
Class 1	$7.00	$11.00	$12.50	$19.00

Voluntary Hospital Indemnity

Most major medical insurance plans only pay a portion of hospitalization costs. Our policy can help pick up where other insurance leaves off and provide cash to cover the expenses. There is a pre-existing limitation. See plan summary for full details. Group Number G000CLHB

When you're hospitalized, expenses can add up quickly.

Hospital stays can be stressful and having to worry about the high costs of hospitalization should not be part of the recovery plan. Hospital Indemnity insurance helps to ease your mind about handling hospitalization costs – even if they are not hospital bills.

A hospital indemnity insurance policy supplements your medical coverage and provides a cash benefit for hospital related fees you or an insured family member sustain as a result of being hospitalized. This benefit can be used to pay out-of-pocket medical expenses, help supplement your daily living expenses and cover unpaid time off work.

As an active employee of Allied Stone, Inc., you have hospital indemnity coverage for yourself and your family members, and premiums can be deducted from your paycheck. Hospital indemnity supplements your existing health insurance coverage by helping pay for out-of-pocket expenses incurred due to an injury or illness that may not be covered under other insurance plans.

BENEFITS

Benefits described in this proposal will only be payable if treatment for injury or sickness occurs on or after the insured person's coverage effective date and while the policy is in-force. The benefit amounts payable are based on the type and amount of insurance in effect on the date treatment of injury or sickness occurs, subject to the definitions, limitations, exclusions, and other provisions of the certificate. This is 24-hour coverage (on and off-job). Maternity is included.

Hospital Admission & Confinement	Amount
Hospital Admission—*limited to a combined total of 1 admission per policy year. Hospital Admission & Hospital ICU Admission benefits are not payable on the same day.*	**Class 1**
Hospital Admission	$1,000 per admission
ICU Admission	$1,000 per admission
Hospital Confinement—*limited to a combined total of 180 days per policy year. Hospital/ICU confinement benefits are not payable on the same day as Hospital/ICU admission benefits.*	**Class 1**
Daily Hospital Confinement	$150 per day
Daily ICU Confinement	$300 per day
Additional Benefits	**Amount**
	Class 1
Health Screening Benefit	$50; 1 time per insured person per calendar year; up to 6 per family per calendar year
Express Benefit (equal to one daily hospital confinement benefit)	$150 per hospital admission

Hospital Indemnity Monthly Premium Rates	Employee/Member	Employee/Member + Spouse	Employee/Member + Child(ren)	Employee/Member + Family
Class 1	$17.25	$34.60	$30.25	$48.65

Voluntary Critical Illness

The signs pointing to a critical illness are not always clear and may not be preventable, but our coverage can help offer financial protection in the event you are diagnosed. Mutual of Omaha Insurance Company group voluntary critical illness coverage provides a lump-sum cash benefit to help you cover the out-of-pocket expenses associated with a critical illness. See plan summary for full details.

Group Number G000CLHB.

AMOUNT(S) OF INSURANCE

CRITICAL ILLNESS (CI)

The CI insurance amount for the employee/member and any dependent(s) is selected at time of enrollment within the following parameters. Child insurance is automatic (a separate election is not required).

	Minimum Amount	Maximum Amount	Increments	Guarantee Issue Amount*
Employee/Member	$5,000	$30,000	$5,000	$30,000
Spouse	$5,000	100% of employee/member benefit amount, up to $30,000**	$5,000	$30,000
All Children†	50% of employee/member benefit, up to $15,000**			$15,000

*Guarantee Issue is only available if the minimum participation requirement is met. If participation does not reach the required level, the Guarantee Issue Amount(s) may be reduced or rescinded.

**The amount of insurance for any dependent will be rounded to the next higher multiple of $1,000, if not already an even multiple of $1,000.

†Child coverage begins at birth and terminates at age 26 unless the child is incapacitated.

CRITICAL ILLNESS PREMIUM RATES

Age Band	Employee/ Member* Monthly Rates per $1,000
<30	$0.340
30 - 39	$0.486
40 - 49	$0.828
50 - 59	$1.410
60 - 69	$2.336
70 - 79	$2.871
80 - 99	$3.109

*Employee/member and spouse premiums are calculated with the employee/member's age as of the effective date of the plan. Rates are adjusted once each year on the plan anniversary date that coincides with or follows the day an employee/member reaches the starting age of the next age band.

2026 Benefits Open Enrollment

November 9 - November 22

Visit the Benefits Homepage by using the QR Code or link provided below

SCAN ME

SCAN THE QR CODE OR USE THE LINK TO VISIT THE BENEFITS HOMEPAGE

1. **Review** the Benefits Guide and other educational tools to learn more about your benefit offerings

2. **Schedule** your personalized appointment with a Benefits Counselor to learn more about your benefit options

3. **Enroll** in Benefits! Be sure to have new dependent and beneficiary SS# and DOB available to complete your enrollment

ALLIED INTERIORS GROUP

Allied Stone | Allied Gallery | Square Cabinetry | Allied Interior Solutions

https://alliedinteriors.benefitsinfo.com

We speak insurance.

Call the Benefit Resource Center (BRC). We're here to help!

"Services denied?"

"Why won't they pay my claim?"

"How can my claim still be in process? It's been two months!"

"I called my insurance carrier, but now I'm just more confused."

"Do I have mail-order prescription benefits?"

Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution
- Medicare basics with your employer plan
- Coordination of benefits
- Finding in-network providers
- Access to care issues
- Obtaining case management services
- Group disability claims

Benefits Resource Center

BRCSouthwest@usi.com | Toll Free: 855-874-0110 | Monday – Friday • 8am – 5pm EST & CST

Contacts

Have Questions? Need Help?

Allied Interiors Group is excited to offer access to the USI Benefit Resource Center (BRC), which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals, and their primary responsibility is to assist you.

The Specialists in the Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time at 855-874-0110 or via e-mail at BRCSouthwest@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or e-mail message by the end of the following business day.

Please contact HR to complete any changes to your benefits that are not related to your initial or annual enrollment.

Carrier Customer Service

BENEFITS PLAN	CARRIER	PHONE NUMBER	WEBSITE
Medical PPO	Curative Insurance Company	855-428-7284	www.curative.com
Medical Indemnity	The American Worker Group 1609	866-866-3424	www.multiplan.com/awp
Dental PPO	Mutual of Omaha Group G000CLHB	800- 927-9197	www.mutualofomaha.com
Vision	Mutual of Omaha Group G000CLHB	833-279-4358	www.mutualofomaha.com
Flexible Spending Account (FSA)	iSolved	866-370-3040	https://www.isolvedbenefitservices.com/benefits/fsa
Life and AD&D	Mutual of Omaha Group G000CLHB	800-775-8805 or 800 877 5176	www.mutualofomaha.com
Voluntary Life and AD&D	Mutual of Omaha Group G000CLHB	800-775-8805 or 800 877 5176	www.mutualofomaha.com
Voluntary Critical Illness	Mutual of Omaha Group G000CLHB	877-775-8805 or 800 877 5176	www.mutualofomaha.com
Hospitalization Only	Mutual of Omaha Group G000CLHB	877-775-8805 or 800 877 5176	www.mutualofomaha.com
Accident	Mutual of Omaha Group G000CLHB	877-775-8805 or 800 877 5176	www.mutualofomaha.com
BRC – Benefits Resource Center	USI	855-874-0110	BRCSouthwest@usi.com (email)

Allied Human Resources

HR@alliedstoneinc.com

4055 Valley View Ln Suite 500

Dallas, Texas 75244

IMPORTANT: The Core Plan includes a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the
- employer.

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (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.

NEWBORNS ACT DISCLOSURE – FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

PATIENT PROTECTION MODEL DISCLOSURE

Curative generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Curative at 855-428-7284 / health@curative.com / www.curative.com

You do not need prior authorization from Curative or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Curative at 855-428-7284 / health@curative.com / www.curative.com

STATEMENT OF ERISA RIGHTS

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 participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of 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 Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in 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 due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or 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 (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Kim Nguyen
4055 Valley View Ln, Ste 500
Dallas, Texas United States 75244
214-838-2225 x023
KimN@alliedinteriorsgroup.com

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****.*
Contact information for questions or complaints is available at the end of the notice.

Your Rights

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

Your Choices

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

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

Our Uses and Disclosures

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

Your Rights

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, usually 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.

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 up to 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 using the information at the end of this notice.

- 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/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

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
  Sales of your information

Our Uses and Disclosures

How do we typically use or share your health 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.

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.

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.

How else can we use or share your health information?

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/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain 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/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Effective Date of this Notice: 01/01/2026
- Privacy Official: Kim Nguyen / KimN@alliedinteriorsgroup.com / 214-838-2225 x023

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

Important Notice from Allied Interiors Group About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Allied Interiors Group and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.
There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Allied Interiors Group has determined that the prescription drug coverage offered by the Curative EPO, PPO, PPO+ plans for the plan year 2026 are, 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.

3. Allied Interiors Group has determined that the prescription drug coverage offered by the The American Worker Plan for the plan year 2026 is, on average for all plan participants, **NOT** expected to pay out as much as standard Medicare prescription drug coverage pays. **Therefore, your coverage is considered Non-Creditable Coverage.** This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Allied Interiors Group plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
4. You can keep your current coverage from Allied Interiors Group. However, because your coverage is **non-creditable**, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you 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, the following options may apply:

- You may stay in the Allied Interiors Gorup plans and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
- If you lose Allied Interiors Group creditable coverage. You may stay in the Allied Interiors Group Plans and also enroll in a Medicare prescription drug plan. The Allied Interiors Group will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer. You may decline coverage in the Allied Interiors Group plans and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the
- Allied Interiors Group plans, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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

You should also know that if you drop or lose your current coverage with Allied Interiors Group and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Allied Interiors Group changes. You also may request a copy of this notice at any time. **For More Information About Your Options Under Medicare Prescription Drug Coverage…**

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

For more information about Medicare prescription drug coverage:

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

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

Date:	01/01/2026
Name/Entity of Sender:	Allied Interiors Group
Contact Position/Office:	Kim Nguyen / Director of Total Rewards
Address:	4055 Valley View Ln, Suite 500, Dallas, TX 75244
Phone Number:	214-838-2225 ext.023

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 January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid

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

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

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+)

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

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – 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

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/

Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – 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

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

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. 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

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

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

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

Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

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 January 31, 2024, 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

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

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

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[2]

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

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

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

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan. There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more detail

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender:	Allied Interiors Group
Contact-Position/Office:	Kim Nguyen / Director of Total Awards
Address:	4055 Valley View Lane, Suite 500, Dallas, TX 75244
Phone Number:	214-838-2225 ext. 023

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.

5. Employer Name	6. Employer Identification Number (EIN)	
Allied Interiors Group	73-1571695	
7. Employer address	8. Employer phone number	
4055 Valley View Lane, Suite 500	214-838-2225	
9. City	10. State	11. ZIP code
Dallas	TX	75244
12. Who can we contact about employee health coverage at this job?		
Kim Nguyen		
13. Phone number (if different from above)	14. Email address	
214-838-2225 x023	**KimN@alliedinteriorsgroup.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 full-time employees working 30 or more hours per week.

  - [ ] Some employees. Eligible employees are:

- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:

    Legal spouse and/or dependent children up to age 26

  - [ ] We do not offer coverage.

[x] 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.

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