King George, LLC
CAFETERIA PLAN
BASIC PLAN DOCUMENT

TABLE OF CONTENTS

ARTICLE I.
INTRODUCTION

1.1 **Establishment/Restatement.** By execution of this document, the Employer hereby establishes or amends and restates (as indicated in Exhibit A) the Plan as of the Effective Date.

1.2 **Purpose.** The purpose of the Plan is to provide Participants with a choice between cash and certain "qualified benefits" as defined in Section 125 of the Code and identified in Exhibit B (referred to herein as "Component Benefits"). The Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Code so that Component Benefits a Participant elects to receive under the Plan will be eligible for exclusion from the Participant's gross income to the fullest extent possible under the Code. Providing Component Benefits through this Plan does not relieve the Employer from satisfying requirements applicable to the particular Component Benefits (e.g., nondiscrimination testing, written plan document, etc.).

1.3 **Plan Documentation**. The official cafeteria plan document for an Employer consists of (1) this written document, (2) the Employer specific information and design decisions reflected in Exhibit A, and (3) the Component Benefits described in Exhibit B. All three parts must be present and competed in order for there to be a cafeteria plan.

1.4 **HIPAA Privacy and Security Rules**. Portions of this Plan are "covered entities" for purposes of the Privacy Rules and the Security Rules.

1.5 **ERISA/Non-ERISA**. Certain employers are subject to the Employee Retirement Income Security Act of 1974 ("ERISA") with respect to certain benefits provided to employees. In addition, certain benefits are not subject to ERISA regardless of the employer that sponsors them. ERISA imposes requirements on the way in which many types of benefits must be provided. Throughout this written document (including Exhibits A and B), language identified as applying to ERISA plans is only applicable to Employers subject to ERISA. Language identified as not applying to ERISA plans is only applicable to Employers that are not subject to ERISA. In general, Employers that are governmental entities, public schools, churches and some church-related entities, and some Indian Tribe operations are not subject to ERISA. It is the Employer's responsibility to determine whether it is subject to ERISA.

ARTICLE II.
DEFINITIONS

The following words and phrases are used in this Plan and shall have the meanings set forth in this Article unless a different meaning is clearly required by the context or is defined within an Article.

2.1 **Cafeteria Plan Regulations** means any final regulations, or proposed regulations on which employers may rely, issued by the Department of Treasury under Section 125 of the Code.

2.2 **Cash Payment** means the amount received by a Participant described in Article XX, if applicable.

2.3 **Change in Status** means the situations that permit an Eligible Employee or Participant to make a change in his or her Election mid-Plan Year and include events that:

(a) Change an Eligible Employee's or Participant's legal (under applicable state and federal law) marital status;

(b) Change the number of an Eligible Employee's or Participant's dependents (as defined in Section 5.4);

(c) Change an Eligible Employee's or Participant's employment status, or the employment status of the Participant's Spouse or dependents (as defined in Section 5.4);

(d) Cause an Eligible Employee's or Participant's dependent (as defined in Section 5.4) to satisfy or cease to satisfy the eligibility requirements for a Component Benefit; and

(e) Change the place of residence of an Eligible Employee or Participant, or his or her Spouse or dependents (as defined in Section 5.4).

2.4 **Claims Administrator** means the entity, if any, determined under Section 6.1.

2.5 **Code** means the Internal Revenue Code of 1986, as amended from time to time.

2.6 **Compensation** means the total salary, wages, bonuses, pay for overtime, vacation pay, sick pay, pay for shift differentials, and other cash compensation paid by the Employer to a Participant (without regard to any salary reduction under this Plan or any pre-tax program recognized under the Code), but excluding reimbursed expenses, car expense allowances, credits for benefits under any plan of deferred compensation to which the Employer contributes, and any additional compensation payable in a form other than cash.

2.7 **Covered Individual** means a person, including a Participant, a Dependent of a Participant, a Spouse of a Participant, and any other person, appropriately covered under a Component Benefit subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA).

2.8 **Dependent** means "Dependent" as defined in each Component Benefit provision in which such term is used. Dependent is not necessarily the same as a dependent for tax purposes. See the definition of Tax Dependent in Section 2.36.

2.9 **Effective Date** means the date specified in Exhibit A on which the Plan, or Plan restatement, is effective and applicable to the Eligible Employees and Participants.

2.10 **Election** means the choice of Component Benefits and means of payment made by the Participant, as described in Article V.

2.11 **Election Period** means the period of time identified by the Plan Administrator prior to the start of a Plan Year during which a Participant may change his or her Election. For a Participant who enters the Plan other than at the start of a Plan Year, Election Period means the period of time identified by the Plan Administrator prior to the date on which the Eligible Employee begins participation during which an Eligible Employee may make an Election or change a deemed Election.

2.12 **Electronic Protected Health Information ("ePHI")** means PHI maintained or transmitted in electronic media including, but not limited to, electronic storage media (i.e., hard drives, digital memory medium) and transmission media used to exchange information in electronic storage media (i.e., internet, extranet, and other networks). PHI transmitted via facsimile and telephone is not considered to be transmissions via electronic media.

2.13 **Eligible Employee** means each Employee who has met the eligibility requirements of Section 3.1.

2.14 **Employee** means any person employed by the Employer and on the Employer's W-2 payroll on or after the Effective Date, except that it shall not include:

(a) Any self-employed individual as described in Section 401(c) of the Code;

(b) Any employee included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the employee under this Plan;

(c) Any employee who is a nonresident alien and receives no earned income from the Employer from sources within the United States;

(d) Any employee who is a leased employee as defined in Section 414(n)(2) of the Code;

(e) An individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee, whether or not any such persons are on the Employer's W-2 payroll or are determined by the IRS or others to be common-law employees of the Employer; or

(f) Any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency such as "Kelly," "Manpower," etc., whether or not such individuals are determined by the IRS or others to be common-law employees of the Employer.

All employees who are treated as employed by a single employer under subsections (b), (c) or (m) of Section 414 of the Code are treated as employed by a single employer for purposes of this Plan.

2.15 **Employer** means the Employer named in Exhibit A and any affiliate that, with the consent of the Employer, becomes an Employer by adopting the Plan or any successor business organization that assumes the obligations of the Employer. For non-governmental Employers, "affiliate" means an entity (other than the Employer) which is part of a group of entities which includes the Employer and which constitutes (a) a controlled group of corporations (as defined in Section 414(b) of the Code), (b) a group of trades or businesses, whether or not incorporated, under common control (as defined in Section 414(c) of the Code), or (c) an affiliated service group (within the meaning of Section 414(m) of the Code).

2.16 **Employer Contribution** means amounts, if any, that have not been actually or constructively received by the Participant that are made available to the Participant by the Employer for the purpose of paying for Component Benefits elected under the Plan and as further described in Section 4.4.

2.17 **Entry Date** means the date on which an Eligible Employee becomes eligible for any Component Benefit.

2.18 **ERISA** means the Employee Retirement Income Security Act of 1974, as amended. Governmental entities, public schools, and some church-related entities and some Indian Tribe operations are not subject to ERISA.

2.19 **Highly Compensated Individual** means individuals who are highly compensated as defined in Section 125(e)(2) of the Code.

2.20 **Highly Compensated Participant** means Participants who are highly compensated as defined in Section 125(e)(1) of the Code.

2.21 **HIPAA** means Health Insurance Portability and Accountability Act of 1996, and regulations thereunder, as amended from time to time.

2.22 **HSA** means a health savings account within the meaning of Section 223 of the Code.

2.23 **Insurer** means any insurance company, health maintenance organization, or similar entity that has issued a policy through which benefits are made available under this Plan.

2.24 **IRS** means the Internal Revenue Service.

2.25 **Key Employee** means an Employee who is a "Key Employee" as defined in Section 416(i) of the Code. Governmental employers do not have Key Employees.

2.26 **Component Benefits** means the qualified benefits under Section 125 of the Code made available through this Plan, and identified in Exhibit B. Each Component Benefit may have its own eligibility, participation, nondiscrimination testing, or other requirements which generally must be followed in addition to the requirements under this Plan.

2.27 **Participant** means an Eligible Employee who participates in the Plan in accordance with Article III and has not ceased to be a Participant under Section 3.4.

2.28 **Plan** means this cafeteria plan as may be amended from time to time. This Plan shall be known by the name identified in Exhibit A. The Plan is the delivery method for the Component Benefits.

2.29 **Plan Administrator** means the entity determined under Section 6.1.

2.30 **Plan Year** means the twelve-month period described in Exhibit A. To the extent an initial "short" Plan Year applies, it is described in Exhibit A.

2.31 **Privacy Rules** means the *Standards and Privacy of Individually Identifiable Health Information* at 45 C.F.R. Part 160 and Part 164 at subparts A and E.

2.32 **Protected Health Information ("PHI")** means health information that:

(a) Is created or received by a health plan, health care provider, or health care clearinghouse;

(b) Relates to the past, present, and future physical or mental health or condition of an individual (including "genetic information" as that term is defined in the Genetic Information Nondiscrimination Act of 2008); the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and

(c) Either identifies the individual or reasonably could be used to identify the individual.

2.33 **Security Rules** means the *Security Standards and Implementation Specifications* at 45 C.F.R. Part 160 and Part 164, subpart C.

2.34 **Spouse** means an individual who is (a) legally married to a Participant (under applicable state law), and (b) who is treated as a "spouse" under the Code.

2.35 **Summary Health Information** means "summary health information" as defined in 45 C.F.R. Section 164.504, which generally defines "summary health information" to include information, which may be PHI, that summarizes claims history, claims expenses, or the type of claims experienced by individuals receiving benefits under the Plan from which certain identifiers have been deleted.

2.36 **Tax Dependent** means an individual (other than the Participant and the Participant's Spouse) with respect to whom amounts expended for medical care are excluded from the Participant's gross income under Section 105(b) of the Code, as amended.

ARTICLE III.
ELIGIBILITY AND PARTICIPATION

3.1 **Eligibility Requirements**. Eligibility for this Plan is separate from eligibility for any of the Component Benefits available through this Plan.

(a) **Cafeteria Plan**. An Employee that is covered under a Component Benefit shall be eligible to participate in this Plan for purposes of paying the Participant's share(s) of the cost of the Component Benefit(s) selected. To the extent the Employee is covered under more than one Component Benefit, and the eligibility requirements for the Component Benefits differ, for purposes of eligibility nondiscrimination testing under Section 125 of the Code, the Plan shall be disaggregated into separate pieces and tested separately.

(b) **Component Benefits**. In order to elect a specific Component Benefit provided through this Plan, a Participant must elect that Component Benefit on such forms as the Plan Administrator may require (unless the benefit is provided to all Participants) and, if the cost of Component Benefit is not fully paid by the Employer, shall be required to share the cost of the Component Benefit as provided in Article IV. Further, the Participant must meet any eligibility, participation, etc., requirements applicable to that Component Benefit in accordance with the terms of the underlying plan or program through which the Component Benefit is provided.

Note: This provision applies to *eligibility in this Plan*. With respect to the Component Benefits that involve premium payments for other plans sponsored by the Employer, coverage under the underlying Component Benefit may begin at a different time than coverage under this Plan. This Plan is the way the cost of coverage is paid.

3.2 **Notification of Participants.** The Plan Administrator shall provide each Eligible Employee written notice of the Employee's eligibility to participate in the Plan in sufficient time to enable such Eligible Employee to submit an application for participation in the Plan on or before the applicable Entry Date.

3.3 **Application for Participation.**

(a) **Generally.** In general, unless an Eligible Employee is deemed to have made an Election as provided in Article V, to become a Participant, an Eligible Employee shall execute and deliver to the Plan Administrator, prior to the applicable Entry Date, an application signed by the Eligible Employee in which the Eligible Employee:

(1) Applies to participate in the Plan;

(2) Designates the required portion of Compensation for the pre-tax and after-tax (if any) contributions;

(3) Makes a benefit Election; and

(4) Supplies any other pertinent information that the Plan Administrator may reasonably require.

By signing such application or agreement, the Eligible Employee shall be deemed for all purposes to have agreed to participate and to conform to the requirements of the Plan. Such application or agreement may be the same as, or separate from, the application or agreement required to participate in any Component Benefit under this Plan. Alternatively, or in addition to the forgoing application process, the Plan Administrator may require or permit application of same scope by electronic means. Participation shall begin on a Participant's Entry Date.

(b) **Special Rule -- Newly Hired.** If indicated in Exhibit A, a special eligibility rule may apply with respect to the Group Medical Coverage for new hires. If the Group Medical Coverage provide, a newly hired Eligible Employee shall execute and deliver to the Plan Administrator within thirty (30) days of employment, a written application. If the Group Medical Coverage provide, participation in this Plan is retroactive to the date of hire pursuant to Cafeteria Plan Regulations. However, salary reduction contributions to pay for the Group Medical Coverage during the period preceding the submission of the application shall be taken prospectively from compensation paid following submission of the application. This special eligibility rule is only available if the Group Medical Coverage provide and only with respect to the Group Medical Coverage.

3.4 **Termination of Participation**. Participant automatically ceases to be a Participant at midnight of the earliest of the following dates:

(a) The death of the Participant;

(b) The date of termination of the Participant's employment with the Employer;

(c) The date of the Participant's failure to meet the eligibility requirements of Section 3.1, as may be amended from time to time; or

(d) The date of termination of the Plan in accordance with Article VII.

Note: This provision applies to *participation in this Plan*. With respect to the Component Benefits that involve premium payments for other plans sponsored be the Employer, coverage under the underlying plan may extend beyond the date on which a Participant ceases to be a Participant in this Plan. For example, many insurance contracts provide coverage through the end of the month.

In the event the Plan does not learn that a Participant has automatically ceased to be a Participant until a date after the date participation ceased, participation will be terminated retroactively and the Plan shall be entitled to recover any amounts paid as benefits paid after the date participation is terminated. Termination of participation in this Plan shall not prevent a former Participant from continuation coverage, conversion coverage or benefits under the respective Component Benefit if and to the extent provided by such plans.

3.5 **Conditions of Participation**. As a condition of participation and receipt of benefits under this Plan, the Participant agrees to:

(a) Observe all Plan rules and regulations;

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

(c) Submit to the Plan Administrator all notifications, reports, bills, and other information required by the Plan or which the Plan Administrator may reasonably require; and

(d) Repay any overpayments or incorrect payments received under the Plan.

Failure to do so relieves the Plan, Plan Administrator, and Claims Administrator, if any, from any and all obligations under this Plan.

ARTICLE IV.
CONTRIBUTIONS

4.1 **Salary Reduction Contributions.** To the extent the Participant's cost of a Component Benefit exceeds the Employer Contribution (if any), a Participant may elect in accordance with the Election procedures described in Article V to receive his or her full Compensation in cash, or to have a portion of such Compensation applied by the Employer toward the Participant's cost of Component Benefits. If so elected, the Participant's Compensation will be reduced, and an amount equal to the reduction shall be allocated by the Employer to the Component Benefits designated by the Participant. A Participant's Compensation shall be reduced by pro-rata amounts of the Participant's total salary reduction Election. Salary reduction is done on a pre-tax basis before any withholdings have been made. The frequency of salary reduction contributions shall be as identified in Exhibit A. Notwithstanding the forgoing, if participation in a Component Benefit extends to the last day of the month in which a Participant's employment terminates, if necessary, additional salary reduction contributions shall be taken from the Participant's final pay check to pay for the coverage provided during the period of time following the date on which the Participant's employment terminates.

4.2 **Salary Deduction Contributions.** The Employer may require that amounts for which the Participant is responsible, but which cannot be paid with pre-tax dollars through salary reduction described above, be funded with after-tax dollars pursuant to a salary deduction agreement. Such salary deductions shall be made on a periodic basis and relate to a Participant's Compensation after taxes and withholdings have been made.

4.3 **Imputation of Income.** To the extent a Participant participates in a Component Benefit that covers a Dependent who is not the Participant's Spouse or Tax Dependent, the entire cost of coverage for which the Participant is responsible shall be paid pre-tax through this Plan and the fair market value of the coverage for that Dependent shall be imputed as income to the Participant as the coverage is provided (pursuant to Cafeteria Plan Regulations). This provision applies regardless of whether the cost of coverage is paid by salary reduction or allocation of available Employer Contributions, if any.

4.4 **Employer Contribution.** The Employer may make a fixed dollar contribution to the Plan that Participants may use to purchase Component Benefits. The amount of the Employer Contribution, if any, and any restrictions on the eligibility for or use thereof shall be communicated to the Participants prior to the start of each Plan Year so that they may consider it in making their Elections. The annual Employer Contribution amount shall be prorated and made available in equal monthly installments. The amount of the Employer Contribution may change from year to year as announced by the Employer prior to the Plan Year start. No Employer Contribution shall be credited to any Employee during a period of leave of absence, whether authorized or unauthorized, unless required by the Family Medical Leave Act ("FMLA"), if applicable. Employees who are not eligible for participation on the first day of the Plan Year shall have their annual Employer Contribution pro-rated by multiplying the annual available Employer Contribution by a fraction, the numerator of which is the number of months the Employee is eligible for participation for the Plan Year, the denominator which is twelve.

4.5 **Maximum Under the Plan.** Under no circumstances may a Participant's total salary reduction exceed the sum of (a) the cost of benefits paid on a pre-tax basis provided through insurance or insurance types of benefits plus (b) the maximum Election amounts permitted under the reimbursement-type Component Benefits plus (c) the maximum Election permitted under the HSA Contribution Feature (if applicable) minus (d) the Employer Contribution, if any.

4.6 **No Trust.**

(a) **Generally.** Nothing in this Plan is intended to require the establishment of a trust. Employer Contributions made to this Plan remain the Employer's general assets until used to pay benefits or purchase coverage through the Plan. Participant contributions to the Plan including, but not limited to, salary reduction contributions, are Plan assets.

(b) **Entities Subject to ERISA.** To the extent ERISA applies, such Plan assets are not required to be held in trust pursuant to ERISA Technical Release 92-01. For all other purposes not addressed in ERISA Technical Release 92-01, such amounts retain their character and shall be treated as Plan assets.

4.7 **Insurer Refunds**.

(a) **Generally.** Any refund provided to the Employer by an Insurer that has issued an insurance contract for any Component Benefit shall constitute Plan assets only to the extent required by applicable law.

(b) **Entities Subject to ERISA.** If the Component Benefit is subject to ERISA, the refund shall be allocated between the Employer and the Participants in accordance with the then prevailing United States Department of Labor (DOL) guidance. The portion of the refund allocated to Participants shall be (a) used solely for the benefit of the Participants participating in the Component Benefit with respect to which the refund was provided, and (b) returned to such Participants in a manner allowed by applicable law (e.g., to provide a refund of Participant premiums, a premium holiday, an increase in benefits, etc.), as determined by the Plan Administrator in its sole discretion. The portion of the refund allocated to Participants shall be returned to the Participants no later than three (3) months following the date on which the Employer receives such refund from the Insurer.

(c) **Entities not Subject to ERISA.** If the Component Benefit is not subject to ERISA, the refund shall be allocated and used as required under applicable law.

ARTICLE V.
ELECTION OF AVAILABLE BENEFITS

5.1 **Initial Elections.** Except as provided in Section 3.3(b), an Election must have been made prior to the date on which an Eligible Employee becomes a Participant. Unless otherwise specified in Exhibit A, upon initial eligibility, Elections shall be made as follows.

(a) **Affirmative Elections.** With respect to Component Benefits other than those providing group insurance-type Component Benefits, an affirmative Election to participate is required as part of the application to participate described in 3.3. If the Election Period ends and an Election has not been received by the Plan Administrator, the Eligible Employee will be deemed to have elected not to participate in the above-referenced Component Benefits, provided that any unused Employer Contributions shall be handled as provided in the Exhibit A.

(b) **Automatic Elections.** With respect to Component Benefits providing group insurance type Component Benefits, an Eligible Employee is deemed to have elected to participate and to pay the Participant's share of the cost of such Component Benefits through salary reduction unless (1) the Eligible Employee specifically elects not to participate with respect to such Component Benefit(s) and notifies the Plan Administrator in writing on or before the close of the Election Period, or (2) such deemed Election is otherwise prohibited by law.

(c) **Special Rule -- Newly Hired.** To the extent a special eligibility rule applies as described in 3.3(b), the requirements of that special eligibility rule apply.

5.2 **Subsequent Elections**. During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to change his or her Election, including the following:

(a) An Eligible Employee who is not participating may elect to begin participating by electing Component Benefits during the Election Period;

(b) A Participant may terminate participation in the Plan;

(c) A Participant may elect different Component Benefits or different levels of Component Benefits.

An Election must have been made, or deemed to have been made, prior to the start of the Plan Year to which it relates.

5.3 **Failure to Make Annual Election.** Unless otherwise specified in Exhibit A, if a Participant does not make a new Election during the Election Period prior to each Plan Year, then:

(a) **Affirmative Elections.** With respect to Component Benefits other than those providing for premium payments for group coverage, the Participant shall be deemed to have elected not to participate in such Component Benefits for the upcoming Plan Year, provided that any unused Employer Contribution shall be handled as provided in Exhibit A.

(b) **Automatic Elections.** With respect to Component Benefits providing for premium payments for group coverage, the Participant shall be deemed, unless prohibited by law, to have elected to pay any portion of the cost for which the Participant is responsible through salary reduction unless (1) the Eligible Employee specifically elects not to participate with respect to such Component Benefit(s) and notifies the Plan Administrator in writing on or before the close of the Election Period, or (2) such deemed Election is otherwise prohibited by law.

5.4 **Elections Irrevocable.**

Unless modified in Exhibit A, an Election becomes effective and shall be irrevocable for the Plan Year or the remainder of the Plan Year except under the following circumstances:

(a) **Change in Status.** A Participant may change or terminate his or her actual or deemed Election under the Plan upon the occurrence of a Change in Status, but only if such change or termination is made on account of and corresponds with a Change in Status that affects coverage eligibility of a Participant, a Participant's Spouse, or a Participant's Dependent (referred to as the general consistency requirement). The Plan Administrator (in its sole discretion) shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her Election based on that change.

(1) **Loss of Dependent Eligibility.** For a Change in Status involving a Participant's divorce or domestic partnership, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance, or insurance type, coverage for the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or Dependent, or the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances does not correspond with that Change in Status.

(2) **Gain of Coverage Eligibility Under Another Employer's Plan.** For a Change in Status in which a Participant, a Participant's Spouse or Domestic Partner, or a Participant's Dependent gains eligibility for coverage under another employer's cafeteria plan (or another employer's qualified benefit plan) as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage only if that coverage becomes effective or is increased under the other employer's plan.

(3) **Group Term Life Coverage and Group Disability Coverage.** For a Change of Status involving a Participant's legal marital status or the employment status of a Participant's Spouse or Dependent (disregarding the requirement that the event cause a loss or gain of eligibility), a Participant may elect either to increase or to decrease Group Term Life Coverage or Group Disability Coverage offered under the Plan.

(4) **COBRA Coverage.** If the Participant becomes eligible for continuation under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") (or similar health plan continuation coverage under state law) under a Component Benefit, the Participant may increase the Election for that Component Benefit to pay for such coverage provided the Participant remains eligible to participate in the Plan and still receives Compensation.

(b) **HIPAA Special Enrollment Rights.** If a Participant, a Participant's Spouse, and/or a Participant's dependent enrolls in a group health plan that is a Component Benefit of this Plan and subject to the HIPAA special enrollment rights provided by Code § 9801(f), the Participant may make a new election that corresponds with the special enrollment. For purposes of this provision (1) an Election to add previously eligible dependents as a result of the acquisition of a new Spouse or dependent child (a/k/a the Tag-along Rule), shall be considered consistent with the special enrollment right; and (2) a HIPAA special enrollment Election attributable to the birth or adoption of a new dependent child may be effective retroactive (up to thirty (30) days), provided it applies to Compensation not yet currently available.

(c) **Certain Judgments, Decrees and Orders.** If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) requires accident or health coverage for a Participant's Dependent child (including a foster child who is a Dependent of the Participant), a Participant may: (1) change his or her Election to provide coverage for the Dependent child (provided that the Order requires the Participant to provide coverage and subject to the provisions of the underlying group health plan); or (2) change his or her Election to revoke coverage for the Dependent child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan.

(d) **Medicare and Medicaid.** If a Participant, a Participant's Spouse, or a Participant's Dependent who is enrolled in a health or accident benefit under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid. Further, if a Participant, a Participant's Spouse, or a Participant's Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the health or accident coverage provided under this Plan of the person losing entitlement to Medicare or Medicaid.

(e) **Change in Cost.**

(1) **Automatic Increase or Decrease for Insignificant Cost Changes.** If the cost of a Component Benefit increases or decreases during a Plan Year by an insignificant amount, then the pre-tax contributions or after-tax contributions (as applicable) under each affected Participant Election shall be prospectively increased or decreased to reflect such change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this prospective increase or decrease in Participant contributions in accordance with such cost changes. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether increases or decreases in costs are "insignificant" based upon all the surrounding facts and circumstances (including, but not limited to, the dollar amount or percentage of the cost change).

(2) **Significant Cost Increases.** If the Plan Administrator determines that the cost of a Component Benefit significantly increases during a Plan Year, the Participant may, on a prospective basis, either (a) make a corresponding increase in his or her Election, (b) enroll in another benefit package option providing similar coverage and make a corresponding Election change, or (c) revoke his or her Election if no other benefit package option providing similar coverage is available. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant and what constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(3) **Significant Cost Decrease.** If the Plan Administrator determines that the cost of a Component Benefit significantly decreases during a Plan Year: (i) an Eligible Employee or Participant may commence participation in such Component Benefit;

and (ii) the Plan Administrator shall automatically effectuate a prospective decrease in a Participant's Election with respect to such Component Benefit in accordance with the cost decrease.

(f) **Change in Coverage.**

(1) **Significant Curtailment.** If the Plan Administrator determines that coverage under a Component Benefit is significantly curtailed during a Plan Year, the Participant may prospectively enroll in another benefit package option providing similar coverage and make a corresponding Election change. Coverage under an accident or health plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided to Participants under the Plan so as to constitute reduced coverage to Participants in general. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant", and whether a substitute Component Benefit constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(2) **Loss of Coverage.** If the Plan Administrator determines that coverage under a Component Benefit, the Participant may, on a prospective basis: (i) enroll in another benefit package option providing similar coverage and make a corresponding Election change; or (it) revoke his or her Election if no other benefit package option providing similar coverage is available. Coverage under an accident or health plan is deemed "lost" only if there is a complete loss of coverage under the benefit package option (e.g., due to elimination of the benefit package option or application of an annual or lifetime maximum) or other fundamental loss of coverage. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a "loss" has occurred, and whether a benefit package option constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(3) **Addition or Improvement of a Component Benefit.** If during a Plan Year, the Plan adds a new Component Benefit or a new benefit package option under the Component Benefit, or if coverage under an existing Component Benefit is significantly improved: (i) an affected Participant may prospectively change his/her Election with respect to the newly-added or improved Component Benefit; and (it) an Eligible Employee may commence participation in such Component Benefit. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a Component Benefit has been "significantly improved" based upon all the surrounding facts and circumstances.

(4) **Change Under Another Employer Sponsored Plan.** A Participant may make a prospective Election change that is on account of and corresponds with a change made under another employer-sponsored plan (including a plan of the Employer or a plan of another employer), provided (i) the other cafeteria plan or qualified benefits plan permits its participants to make an Election change that would be permitted under the Cafeteria Plan Regulations, or (ii) this Plan permits Participants to make an Election for a Plan Year period of coverage which is different from the plan year period of coverage under the other cafeteria plan or Component Benefit. The Plan Administrator shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under another employer-sponsored plan.

(5) **Loss of Governmental or Educational Coverage.** A Participant may prospectively change his or her Election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program ("SCHIP") under Title of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable benefit package option(s).

(6) **Enrollment in Marketplace Coverage.**

(i) A Participant who has made an Election to pay for Group Medical Coverage may revoke that Election if the following conditions are satisfied:

(A) The Participant either (I) is eligible to enroll in a qualified health plan through a public insurance exchange (the "Marketplace") via a special enrollment period (as provided in any guidance issued by the Department of Health and Human Services or any other applicable guidance), or (Il) seeks to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period;

(B) The Participant cancels coverage under the Group Medical Coverage in accordance with the terms and conditions of that plan; and

(C) The Participant, and any related individuals who were also enrolled in the Group Medical Coverage, have enrolled in or intend to enroll in a qualified health plan through the Marketplace that will be effective no later than the day immediately following the last day for which coverage under the Group Medical Coverage was effective (i.e., there is no break in coverage). The Plan Administrator will require proof of marketplace coverage to terminate your coverage with King George, LLC.

(D) Unless determined by the IRS not to be available, a Participant who has made an Election to pay for Group Medical Coverage may reduce that Election if the following conditions are satisfied:

(E) The Participant's Spouse and/or dependents either (I) are eligible to enroll in a qualified health plan through the Marketplace via a special enrollment period (as provided in any guidance issued by the Department of Health and Human Services or any other applicable guidance), or (Il) seek to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period;

(F) The Participant cancels coverage under the Group Medical Coverage for such Spouse and/or dependents in accordance with the terms and conditions of that plan; and

(G) Such Spouse and/or dependents have enrolled in or intend to enroll in a qualified health plan through the Marketplace that will be effective no later than the day immediately following the last day for which the coverage under the Group Medical Coverage was effective (i.e., there is no break in coverage). The Plan Administrator will require proof of marketplace coverage to terminate your coverage with King George, LLC.

(g) **Reduction in Hours Without Loss of Eligibility.** A Participant who has made an Election to pay for Group Medical Coverage may revoke that Election if the following conditions are satisfied:

(1) The Participant has been in an employment status under which the Participant was reasonably expected to average at least thirty (30) hours of service per week;

(2) The Participant has experienced a change in employment status such that the Participant will reasonably be expected to average less than thirty (30) hours of service per week after the change but nevertheless remains eligible for Group Medical Coverage;

(3) The Participant cancels coverage under the Group Medical Coverage in accordance with the terms and conditions of that plan; and

(4) The Participant, and any related individuals who were also enrolled in the Group Medical Coverage, have enrolled or intend to enroll in other medical coverage that provides minimum essential coverage and that will be effective no later than the first day of the second month following the month in which coverage under the Group Medical Coverage ends. The Plan Administrator may rely on the reasonable representation of the Participant that the requirements of this paragraph (4) are met.

(h) **Family and Medical Leave Act.** A Participant taking a leave governed by the Family and Medical Leave Act of 1993 ("FMLA") may revoke or change an Election as may be provided for under the FMLA and the Employer's FMLA policy required thereunder, provided the Employer is subject to FMLA.

(i) **Other.** The Plan Administrator shall have the discretion to allow a change to or termination of an Election to the extent such change or termination is the result of any other situation informally recognized by the Internal Revenue Service as providing an exception to the general rule that Elections are irrevocable (e.g., corrections of mistakes, changes to meet nondiscrimination requirements).

A Participant entitled to make a new Election under this Section must do so within thirty (30) days of the event unless applicable law requires a longer election period. An Employee who is eligible to elect benefits but declined to do so during the initial Election period, or during a subsequent Election period, may file a new Election within thirty (30) days of the occurrence of an event described above, but only if the new Election is made on account of and corresponds with the event. Subject to the provisions of the underlying group health plan, Elections made to add medical coverage for a newborn or newly adopted Dependent child pursuant to a HIPAA special enrollment right may be retroactive for up to thirty (30) days. All other new Elections shall be effective prospectively immediately following the date the Participant files the new Election with the Plan Administrator. Elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the Election is made unless a subsequent event (described above) allows a further Election change.

5.5 **Rehire and Eligibility Loss.** Termination of employment shall automatically revoke any Election. Former Participants who are rehired:

(a) After thirty (30) days following a termination of employment, shall have two "periods of coverage;" that period prior to the termination of employment and that period following the re-employment of the terminated Employee. Expenses incurred prior to the termination of employment shall be subject to the Election in effect upon termination; while the Employee shall have an opportunity to make a new Election and expenses incurred after re-employment shall be subject to the Election made upon re-employment.

(b) Within thirty (30) days following a termination of employment, shall have the Election in effect prior to the termination of employment reinstated upon re-employment.

5.6 **Benefit Descriptions.** Although an Election to pay for insurance and insurance-type Component Benefits is made under this Plan, the benefits themselves will be provided in accordance with the documents or contracts describing the types and amounts of benefits available, the requirements for participation, the procedures for submitting claims, and the other terms and conditions of such coverage. Such underlying documents or contracts, if any, are incorporated into this Plan by reference and identified in Exhibit B.

5.7 **Forfeiture.**

(a) **Entities Subject to ERISA.** Any amounts, whether obtained through salary reduction, salary deduction, Employer Contributions, or otherwise, under this Plan that are Plan assets and which cannot be distributed by the Plan Administrator to cover the cost of Component Benefits for the applicable Plan Year, shall be forfeited by the Participant. The Plan Administrator may use such forfeited amounts to defray the reasonable administrative costs of the portion of the Plan yielding the forfeiture. To the extent forfeited amounts remain, the Plan Administrator shall arrange for the provision of a benefit for a broad cross section of Participants of the same type as the benefit which an outside formal or informal arrangement under which the forfeited amounts are allocated among Participants based (directly or indirectly) on their individual claims experience under the Plan. This forfeiture requirement shall be applied separately for each Component Benefit and shall only apply with respect to Plan assets.

(b) **Entities Not Subject to ERISA.** Any amounts, whether obtained through salary reduction, salary deduction, Employer Contributions, or otherwise, under this Plan which cannot be distributed by the Plan Administrator to cover the cost of Component Benefits for the applicable Plan Year, shall be forfeited by the Participant. Forfeited amounts, in accordance with the Cafeteria Plan Regulations, may be: (1) retained by the Employer, (2) used to defray the reasonable administrative costs of the Plan, (3) used to reduce required salary reduction amounts for the immediately following Plan Year on a reasonable and uniform basis, and/or (4) returned to the Participants on a reasonable and uniform basis. Under no circumstances shall the Plan Administrator establish an outside formal or informal arrangement under which the forfeited amounts are allocated among Participants based (directly or indirectly) on their individual claims experience under the Plan.

5.8 **Limitations on Benefits**. Benefits shall be limited as determined by the Plan Administrator in accordance with Section 6.16 for the purpose of ensuring compliance with any nondiscrimination requirement applicable to the Plan and/or a Component Benefit.

ARTICLE VI.
ADMINISTRATION

6.1 **Plan Administrator.**

(a) **Plans Subject to ERISA**. The Plan Administrator shall be responsible for the general supervision of the Plan. The Plan Administrator shall also be the named fiduciary (in accordance with Section 402 of ERISA) of any Component Benefit (if any) that is subject to ERISA unless the underlying plan documentation or insurance contract identifies a different named fiduciary. The Plan Administrator shall have the discretionary authority to control and manage the operation and administration of the Plan, including but not limited to, the interpretation and application of the terms of the Plan. The Plan Administrator shall perform any and all acts necessary or appropriate for the proper management and administration of the Plan. The Employer shall be the Plan Administrator unless provided otherwise in Exhibit A. The Employer shall also be the Plan Administrator if the person or persons so designated cease to be the Plan Administrator. The Plan Administrator may designate an individual or entity to act on its behalf with respect to certain powers, duties, responsibilities, etc. with respect to the operation and administration of this Plan. Where Component Benefits purchased through this Plan are provided through an Insurer, that Insurer shall be responsible with respect to those benefits. In all other situations, the Plan Administrator shall be responsible unless the Plan Administrator contracts with another entity to act on its behalf as a Claims Administrator and that other entity is identified in Exhibit A.

(b) **Plans Not Subject to ERISA**. The Plan Administrator shall be responsible for the general supervision of the Plan. The Plan Administrator shall also be responsible for the general supervision of any Component Benefit unless the underlying plan documentation or insurance contract identifies a different responsible party. The Plan Administrator shall have, to the fullest extent permitted by applicable law, the discretionary authority to control and manage the operation and administration of the Plan, including but not limited to, the interpretation and application of the terms of the Plan. The Plan Administrator shall perform any and all acts necessary or appropriate for the proper management and administration of the Plan. The Employer shall be the Plan Administrator unless provided otherwise in Exhibit A. The Employer shall also be the Plan Administrator if the person or persons so designated cease to be the Plan Administrator. The Plan Administrator may designate an individual or entity to act on its behalf with respect to certain powers, duties, responsibilities, etc. with respect to the operation and administration of this Plan. Where Component Benefits purchased through this Plan are provided through an Insurer, that Insurer shall be responsible with respect to those benefits. In all other situations, the Plan Administrator shall be responsible unless the Plan Administrator contracts with another entity to act on its behalf as a Claims Administrator and that other entity is identified in Exhibit A.

6.2 **Agent for Service of Legal Process**. The agent for service of legal process for the Plan is the Plan Administrator.

6.3 **Allocation of Responsibility for Administration.** The Plan Administrator shall have the sole responsibility for the administration of this Plan as is specifically described in this Plan. The designated representatives of the Plan Administrator shall have only those specific powers, duties, responsibilities, and obligations as are specifically given to them under this Plan. The Plan Administrator warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. It is intended under this Plan that the Plan Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities, and obligations under this Plan and shall not be responsible for any act or failure to act of another Employee of the Employer. Neither the Plan Administrator (including any designee) nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

6.4 **Rules and Decisions**. Except as otherwise specifically provided in the Plan, the Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate to fulfill the purposes of the Plan. All rules and decisions of the Plan Administrator shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant, the Employer, or legal counsel.

6.5 **Procedures**. The Plan Administrator may act at a meeting or in writing. The Plan Administrator may adopt by-laws and regulations as it deems desirable for the conduct of the Plan's affairs and as are consistent with the terms of the Plan.

6.6 **Records and Reports**. The Plan Administrator shall be responsible for complying with all reporting, filing and disclosure requirements for the Plan.

6.7 **Claim for Benefits.** This Section addresses the requirements for claims for certain Component Benefits offered under the Plan and the provisions of general applicability, regardless of whether the Component Benefit is subject to ERISA. Claims requirements for other Component Benefits shall be handled in accordance with the governing documents for those Component Benefits.

A Participant may apply to the Plan for reimbursement of eligible expenses incurred during such Plan Year (and applicable Grace Period if any) by submitting a paper claim, or, if provided in Exhibit A, through electronic payment as described below:

(a) **Paper Claims.** A Participant may make a claim by completing a claim form and submitting such form to the Plan via email, facsimile, mail, or the appropriate website setting forth at least the following:

(1) The amount, data and nature of the expense, including the identity of the individual who incurred the expense;

(2) The name of the person or entity to which the expense was paid;

(3) The Participant's statement that the expense has not been reimbursed and the Participant will not seek reimbursement for the expense; and

(4) Such other information as the Plan may require.

Such claim form shall be accompanied by such bills, invoices, receipts, explanations of benefits ("EOB") issued by a health plan, or other statements from an independent third party as is necessary to establish that an eligible expense has been incurred and the amount of the expense. The Plan is entitled to rely on the information provided on the claim form in processing claims under this Plan. Where circumstances beyond the Participant's control prevent submission within the described time frame, notice of a claim with an explanation of the circumstances may be accepted by the Plan as a timely filing. Claims shall be determined in accordance with Article VI.

Reimbursement shall be made weekly or pursuant to a schedule established by the Plan. Claims (including all information substantiating the claim) must be submitted by the deadline established and communicated by the Plan. Reimbursements shall be made from the Participant's respective reimbursement-type account for eligible expenses incurred during the applicable Plan Year for which the Participant submits the required documentation.

6.8 **Determination of Benefits.** This Section addresses the claims determination and appeal procedures for certain types of Component Benefits identified in Exhibit B, and the provisions of general applicability, regardless of whether any portion of this Plan is subject to ERISA. Claims determination and appeal procedures for other Component Benefits shall be handled in accordance with the governing documents for those Component Benefits.

(a) **Initial Determination.** The Plan shall notify a person within thirty (30) days of receipt of a written claim for benefits of that person's eligibility or non-eligibility for benefits under the Plan. If it is determined that a person is not eligible for benefits or for full benefits, the notice shall set forth:

(1) The specific reasons for the denial;

(2) A specific reference to the provision of the Plan on which the denial is based;

(3) A description of any additional information or material necessary for the claimant to perfect the claim and an explanation of why it is needed; and

(4) An explanation of the Plan's claims review procedure and other appropriate information as to the steps to be taken if the Participant wishes to have the claim reviewed.

If the Plan determines that there are special circumstances requiring additional time to make a decision, the Plan shall notify the Participant of the special circumstances and the date by which a decision is expected to be made, and may extend the time for up to an additional fifteen (15) days.

(b) **Appeals.** If a Participant is determined by the Plan not to be eligible for benefits, or if the Participant believes that he or she is entitled to greater or different benefits, the Participant shall have the opportunity to have the claim reviewed by the Plan by filing a petition an appeal within one hundred eighty (180) days after receipt by the Participant of the notice issued by the Plan. The appeal shall state the specific reasons the Participant believes he or she is entitled to benefits or greater or different benefits.

Within sixty (60) days after receipt of the appeal, the Plan shall afford the Participant (and the Participant's counsel, if any) an opportunity to present the Participant's position to the Plan orally or in writing, and the Participant (or the Participant's counsel) shall have the right to review the pertinent documents.

(c) **Decision on Appeal.** The Plan shall notify the Participant of its decision on appeal in writing within said sixty (60) day period of said decision. If it is determined that a person is not eligible for benefits or for full benefits the notice shall set forth:

(1) The specific reasons for the denial;

(2) A specific reference to the provision of the Plan on which the denial is based;

(3) A statement of the Participant's right to review (on request and at no charge) relevant documents and other information;

(4) If the Plan relied on "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar

criterion was relied on and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and

(5) **Entities Subject to ERISA**. If the Component Benefit is subject to ERISA, a statement of the Participant's right to bring suit under ERISA § 502(a).

6.9 **Authorization of Benefit Payments**. The Plan Administrator shall issue directions to the Employer concerning all benefits which are to be paid from the Employer's assets, pursuant to the provisions of the Plan, and shall warrant at the time the directions are provided that all such directions are in accordance with the Plan.

6.10 **Overpayments.** If a payment for benefits is made by the Plan in excess of the benefit to which a Participant is entitled under the Plan, the Plan shall have the right to recover such overpayment from the Participant. Repayment of an overpayment is a condition of participation in the Plan.

6.11 **Inability to Locate Payee.**

(a) **Entities Subject to ERISA.** If benefits are due under this Plan and the Plan Administrator is unable, after reasonable attempts to do so, to locate the Participant to whom such benefits are payable, such benefits shall be forfeited in accordance with Section 5.7. For purposes of the foregoing, the Plan Administrator shall be deemed to be unable to locate a Participant if a check issued for benefits payable under the Plan has been sent to the payee's last known address and has not been cashed within twelve (12) months of its date of issuance.

(b) **Entities Not Subject to ERISA:** If benefits are due under this Plan and the Plan Administrator is unable, after reasonable attempts to do so, to locate the Participant to whom such benefits are payable, such benefits shall be handled in accordance with applicable state law regarding unclaimed property or escheat. For purposes of the foregoing, the Plan Administrator shall be deemed to be unable to locate a Participant if a check issued for benefits payable under the Plan has been sent to the payee's last known address and has not been cashed within three (3) years of its date of issuance.

6.12 **Facility of Payment.** Whenever, in the Plan Administrator's opinion, a person entitled to receive any payment of a benefit or installment under the Plan is under a legal disability or is incapacitated in any way so as to be unable to manage their financial affairs, the Plan Administrator may request the Employer to make payments to such person, or the Plan Administrator may request the Employer to apply the payment for the benefit of such person in such manner as the Plan Administrator considers advisable. Any payment of a benefit, or installment, in accordance with the provisions of this Section, shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan. To the extent the Plan is not subject to ERISA, the same procedure shall be followed.

6.13 **Other Powers and Duties of the Administrator**. The Plan Administrator shall also have such other duties and powers as may be necessary to discharge its duties under the Plan including, but not limited to, the following:

(a) Discretion to construe and interpret the Plan in a non-discriminatory manner, to decide all questions of eligibility, except to the extent the eligibility determinations are governed by an Insurance Contract, and to determine all questions arising in the administration and application of the Plan, except to the extent such eligibility determinations are governed by an insurance contract;

(b) To receive from the Employer and from Participants such information as shall be necessary for the proper administration of the Plan;

(c) To furnish the Employer, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate; and

(d) To appoint individuals to assist in the administration of the Plan and any other agents the Plan Administrator deems advisable, including legal and actuarial counsel. The Plan Administrator shall not have the power to add to, subtract from, or modify any of the terms of the Plan, to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under this Plan.

6.14 **Indemnification.** To the maximum extent allowed by, and in accordance with, applicable law, the Employer shall indemnify and hold harmless any Employee that is deemed to be a fiduciary against any and all losses, claims, damages, expense (including court costs and attorneys' fees), and liability arising from the Employee's duties and responsibilities in connection with the Plan, unless the same is determined to be intentional or willful.

6.15 **Changes by the Administrator**. If the Plan Administrator determines before or during any Plan Year that the Plan or a Component Benefit may fail to satisfy any nondiscrimination requirement imposed by the Code or other applicable law (including any limitation on benefits provided to Key Employees), the Plan Administrator may take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirements or limitation. Such action may include, without limitation, a modification of Elections by Highly Compensated Participants or Key Employees with or without consent of such Employees and/or a re-characterization within the Plan Year of benefits provided under the Plan as taxable income with or without consent of such Employees.

6.16 **Plan Interpretation.** This Plan will be administered in accordance with its terms. To the fullest extent permitted under applicable law, the Plan Administrator and/or a fiduciary acting as a fiduciary with respect to this Plan, to the extent that such individual or entity is acting in its fiduciary capacity, shall have the complete and final authority, responsibility, and control, in its sole discretion, to manage, administer and operate this Plan, to make factual findings, to construe the terms of this Plan, and to determine all questions arising in connection with the administration, interpretation, and application of this Plan, including, but not limited to, the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. All determinations and decisions will be binding on this Plan, Participants, claimants, and all interested parties.

ARTICLE VII.
PLAN AMENDMENT AND TERMINATION

7.1 **Employer Amendments.** The Employer reserves the right to amend this Plan, or any portion of the Plan, at any time. The Employer expressly may make any amendment it determines necessary or desirable, with or without retroactive effect, to comply with the law. Such amendment shall not affect any right to benefits that accrued prior to such amendment. Such amendment shall be made in writing and in accordance with Section 8.4.

7.2 **Employer's Right to Terminate.** Although the Employer expects the Plan to be maintained for an indefinite time, the Employer reserves the right to terminate the Plan or any portion of the Plan at any time. In the event of the dissolution, merger, consolidation, or reorganization of the Employer, the Plan shall terminate unless the Plan is continued by a successor to the Employer in accordance with the resolution of such successor's managing body. Such termination shall not affect any right to benefits that accrued prior to such termination. Such action shall be taken in writing and in accordance with Section 8.4.

ARTICLE VIII.
GENERAL PROVISIONS

8.1 **Plan Not a Contract of Employment**. The Plan is not an employment agreement and does not assure the continued employment of any Employee or Participant for any period of time. Nothing contained in the Plan shall interfere with the Employer's right to discharge an Employee or Participant at any time, regardless of the effect such discharge may have upon the individual as a Participant in this Plan.

8.2 **No Right to Employer's Assets**. No Employee, Participant or beneficiary thereof shall have any right to, or interest in, any assets of the Employer upon termination of employment, or otherwise except as provided from time to time under this Plan, and then only to the extent of the benefits payable under the Plan to such Employee, Participant or beneficiary thereof. In addition, the Claims Administrator, if any, shall not be liable in any manner for such payments.

8.3 **Non-Alienation of Benefits**. Benefits payable under this Plan shall not be subject to anticipation, alienation, sale, transfer, execution, or levy of any kind either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Participant, prior to actually being received by the person entitled to the benefit under the terms of the Plan. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable under the Plan shall be void. The Employer and/or Plan Administrator shall not in any manner be made liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits under the Plan.

8.4 **Action by Employer**. Whenever the Employer, under the terms of this Plan, is permitted or required to do or perform any act or matter or thing, it shall be done and performed by the managing body of the Employer or such representatives of the Employer as the managing body may designate.

8.5 **No Guarantee of Tax Consequences**. Notwithstanding any provision in this Plan to the contrary, neither this Plan nor the Employer make any commitment or guarantee that any amounts paid to or on behalf of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment is excludable from the Participant's gross income for federal, state, and local income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

8.6 **Indemnification of Employer by Participants.** To the maximum extent allowed by, and in accordance with, applicable law, if any Participant receives one or more payments or reimbursements under this Plan that are not for eligible expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold applicable federal, state or local income tax or Social Security tax from such payment or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal, state and local income tax that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

8.7 **Benefits Provided Through Third Parties.** In the case of any Component Benefit provided through a third party (e.g., an Insurer), if there is any conflict or inconsistency between the description of benefits contained in this Plan and the contract or policy, the terms of the contract or policy shall control, unless prohibited by applicable law or specifically addressed in this Plan.

8.8 **Mistakes and Errors**. It is recognized that in the administration of the Plan, certain administrative and accounting errors may be made or situations may arise by reason of factual errors in information supplied to the Employer or the Plan Administrator. The Employer and/or the Plan Administrator shall have the power to take such equitable steps as may be necessary to correct the mathematical, accounting or factual errors, as they, in their sole discretion, determine(s) to be appropriate.

8.9 **Limitation on Liability**. The Employer does not guarantee benefits payable under any insurance policy or other similar contract described or referred to herein, and any benefits thereunder shall be the exclusive responsibility of the Insurer or other entity that is required to provide such benefits under such policy or contract.

8.10 **Governing Law**. This Plan (and its Component Benefits) shall be construed and enforced according to the laws of the state identified in Exhibit A except to the extent preempted by federal law.

8.11 **Family and Medical Leave Act of 1993**. Notwithstanding any provision of this Plan to contrary, this Plan (and its Component Benefits) shall be operated and maintained in a manner consistent with the Family and Medical Leave Act of 1993 ("FMLA") and the Employer's FMLA policy required thereunder, provided the Employer is subject to the FMLA.

8.12 **Uniformed Services Employment and Reemployment Rights Act of 1994**. Notwithstanding any provision of this Plan to the contrary, this Plan (and its Component Benefits) shall be operated and maintained in a manner consistent with the Uniformed Services Employment and Reemployment Act of 1994 ("USERRA"). The Plan Administrator may within the parameters of the law, establish uniform policies by which to provide such continuation coverage required by USERRA, which shall be incorporated herein by reference.

8.13 **Genetic Information Nondiscrimination Act of 2008**. Notwithstanding any provision of this Plan to contrary, this Plan (and its Component Benefits) shall be operated and maintained in a manner consistent with the Genetic Information Nondiscrimination Act of 2008 ("GINA").

8.14 **Children's Health Insurance Program Reauthorization Act of 2009**. Notwithstanding any provision of the Plan to the contrary, the Plan (and its Component Benefits) shall be operated and maintained in a manner consistent with the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA").

8.15 **Michelle's Law.** Notwithstanding any provision of this Plan to the contrary, and to the extent a Component offered through the Plan is subject to this law, the Plan (and its Component Benefits) shall be operated and maintained in a manner as required by Michelle's Law.

8.16 **Mental Health Parity and Addiction Equity Act of 2008.** Notwithstanding any provision of the Plan to the contrary, and to the extent a Component offered through the Plan is subject to this law, this Plan(and its Component Benefits) shall be operated and maintained in a manner consistent with the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA").

8.17 **Newborns' and Mothers' Health Protection Act of 1996.** Notwithstanding any provision of the Plan to the contrary, and to the extent a Component offered through the Plan is subject to this law, this Plan (and its Component Benefits) shall be operated and maintained in a manner consistent with the Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA").

8.18 **Women's Health and Cancer Rights Act of 1998.** Notwithstanding any provision of the Plan to the contrary, and to the extent a Component offered through the Plan is subject to this law, this Plan (and its Component Benefits) shall be operated and maintained in a manner consistent with the Women's Health and Cancer Rights Act of 1998 ("WHCRA").

ARTICLE IX.
GROUP MEDICAL COVERAGE

9.1 **Separate Written Plan.** For purposes of Sections 105 and 106 of the Code, this Article shall constitute a separate written plan providing for the payment of Insurance Premiums. To the extent necessary, other provisions of the Plan are incorporated by reference in this document.

9.2 **Purpose.** The purpose of this Article is to provide Participants an opportunity to make pre-tax payments for the cost of Group Medical Coverage through the Plan. The Employer provides F Coverage through one or more "plans" within the meaning of Sections 105 and 106 of the Code.

9.3 **Definitions.**

(a) **Dependent** means an individual (e.g., Spouse, child, domestic partner, etc.) who qualifies as a "dependent" under the terms and conditions of the applicable plan document governing the Group Medical Coverage.

(b) **Group Medical Coverage** means the medical coverage made available by the Employer to which the Insurance Premiums relate. It does not include individual insurance policies.

(c) **Highly Compensated Individual** means an individual who is highly compensated as defined in Section 105(h)(5) of the Code.

(d) **Insurance Contract** means (1) any insurance contract secured from an Insurer authorized to do business in the state in which such contract is issued, which has been obtained for the purpose of providing Group Medical Coverage, or (2) a self-insured plan administered by a third party providing Group Medical Coverage.

(e) **Insurance Premiums** means the amount that must be paid on a periodic basis in return for coverage under the Insurance Contract, which may include premiums for continuation coverage provided under applicable federal or state law.

9.4 **Terms, Conditions and Limitations.** The Employer shall secure the necessary Insurance Contracts for the provision of Group Medical Coverage. Coverage under the Group Medical Coverage shall begin, benefits shall be provided, and coverage shall terminate in accordance with the applicable Insurance Contracts. Such Insurance Contracts are expressly incorporated into and made part of this portion of the Plan and identified in Exhibit B.

9.5 **Payments.** The Plan Administrator shall make Insurance Premium payments for the Group Medical Coverage on behalf of the Participant in an amount necessary to provide the benefit applicable to the Participant under this portion of the Plan for the applicable Plan Year. Such payments shall be made from Employer Contributions, if any, provided by the Employer under the Plan and, if necessary, contributions made in accordance with the salary reduction arrangement and other arrangements applicable to the Participant under the terms of the Plan. The appropriate portions shall depend on the coverage elected by the Participant. The Plan Administrator shall also make such payments on behalf of the Participant’s Dependents who are enrolled in the Group Medical Coverage. To the extent a Dependent is provided coverage under the Group Medical Coverage and that Dependent is not the Participant's Spouse or Tax Dependent, the tax consequence of such coverage shall be addressed as described in Section 4.3.

9.6 **Nondiscrimination**. To the extent the Group Medical Coverage is subject to Section 105(h) of the Code or, directly or indirectly, Section 2716 of the Public Health Services Act, it shall not discriminate in favor of Highly Compensated Individuals with respect to eligibility to participate or benefits. If the Plan Administrator determines that the Group Medical Coverage is or may be discriminatory, the Plan Administrator may take action permitted by law to avoid such a result as described in Section 6.16.

9.7 **Medical Child Support Orders.**

(a) **Plans Subject to ERISA.** Notwithstanding any provision of this Plan to the contrary, the Plan shall recognize Qualified Medical Child Support Orders ("QMCSOs") regarding the Group Medical Coverage to the extent required by applicable law.

(b) **Plans Not Subject to ERISA**. Notwithstanding any provision of this Plan to the contrary, the Plan shall recognize medical child support orders regarding the Group Medical Coverage to the extent required by applicable law.

9.8 **Continuation of Coverage**. Continued coverage under the Group Medical Coverage shall be provided if it is required under, and in accordance with, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended. The Plan Administrator may, within the parameters of the law, establish uniform policies by which to provide such continuation coverage required by COBRA, which shall be incorporated herein by reference. There shall also be compliance with applicable state laws concerning continuation of health insurance coverage to the extent not preempted by federal law.

9.9 **HIPAA.** The Group Medical Coverage shall comply with the Privacy Rules and Security Rules under HIPAA (if applicable) as further provided in the Insurance Contract and/or the HIPAA policies established by the "covered entity" (as that term is defined in HIPAA). In addition, the Group Medical Coverage shall comply with the portability requirements under HIPAA.

ARTICLE X.
GROUP DENTAL COVERAGE

10.1 **Separate Written Plan.** For purposes of Sections 105 and 106 of the Code, this Article shall constitute a separate written plan providing for the payment of insurance premiums. To the extent necessary, other provisions of the Plan are incorporated by reference in this document.

10.2 **Purpose.** The purpose of this Article is to provide Participants the opportunity to make pre-tax payments for the cost of Group Dental Coverage through this Plan. The Employer provides Group Dental Coverage through one or more "plans" within the meaning of Sections 105 and 106 of the Code.

10.3 **Definitions.**

(a) **Dependent** means an individual (e.g., Spouse, child, domestic partner, etc.) who qualifies as a "dependent" under the terms and conditions of the applicable plan document governing the Group Dental Coverage.

(b) **Group Dental Coverage** means the dental coverage made available by the Employer to which the Insurance Premiums relate. It does not include individual insurance policies.

(c) **Highly Compensated Individual** means an individual who is highly compensated as defined in Section 105(h)(5) of the Code.

(d) **Insurance Contract** means (1) any insurance contract secured from an Insurer authorized to do business in the state in which such contract is issued, which has been obtained for the purpose of providing Group Dental Coverage; or (2)) a self-insured plan administered by a third party providing Group Dental Coverage.

(e) **Insurance Premiums** means the amount that must be paid on a periodic basis in return for coverage under the Insurance Contract, which may include premiums for continuation coverage provided under applicable federal or state law.

10.4 **Terms, Conditions and Limitations.** The Employer shall secure the necessary Insurance Contracts for the provision of Group Dental Coverage. Coverage under the Group Dental Coverage shall begin, benefits shall be provided, and coverage shall terminate in accordance with the applicable Insurance Contracts. Such Insurance Contracts are expressly incorporated into and made part of this Plan and identified in Exhibit B.

10.5 **Payments.** The Plan Administrator shall make Insurance Premium payments for the Group Dental Coverage on behalf of the Participant in an amount necessary to provide the benefit applicable to the Participant under this portion of the Plan for the applicable Plan Year. Such payments shall be made from Employer Contributions, if any, provided by the Employer under the Plan and, if necessary, contributions made in accordance with the salary reduction arrangement and other arrangements applicable to the Participant under the terms of the Plan. The appropriate portions shall depend on the coverage elected by the Participant. The Plan Administrator shall also make such payments on behalf of the Participant's Dependents who are enrolled in the Group Dental Coverage. To the extent a Dependent is provided coverage under the Group Dental Coverage and that Dependent is not the Participant's Spouse or Tax Dependent, the tax consequence of such coverage shall be addressed as described in Section 4.3.

10.6 **Nondiscrimination.** To the extent the Group Dental Coverage is subject to Section 105(h) of the Code, it shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate or benefits. If the Plan Administrator determines that this portion of the Plan is or may be discriminatory, the Plan Administrator may take action permitted by law to avoid such a result as described in Section 6.16.

10.7 **Medical Child Support.**

(a) **Plans Subject to ERISA.** Notwithstanding any provision of this Plan to the contrary, the Plan shall recognize Qualified Medical Child Support Orders ("QMCSOs") regarding the Group Dental Coverage to the extent required by applicable law.

(b) **Plans Not Subject to ERISA**. Notwithstanding any provision of this Plan to the contrary, the Plan shall recognize medical child support orders regarding the Group Dental Coverage to the extent required by applicable law.

10.8 **Continuation of Coverage.** Continued coverage under the Group Dental Coverage shall be provided if it is required under, and in accordance with, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended. The Plan Administrator may, within the parameters of the law, establish uniform policies by which to provide such continuation coverage. There shall also be compliance with state laws concerning continuation of dental benefit coverage to the extent not preempted by federal law.

10.9 **HIPAA.** The Group Dental Coverage shall comply with the Privacy Rules and Security Rules under HIPAA (if applicable) as further provided in the Insurance Contract and/or the HIPAA policies established by the "covered entity" (as that term is defined in HIPAA).

ARTICLE XI.
GROUP VISION COVERAGE

11.1 **Separate Written Plan.** For purposes of Sections 105 and 106 of the Code, this Article shall constitute a separate written plan providing for the direct payment of Insurance Premiums. To the extent necessary, other provisions of the Plan are incorporated by reference.

11.2 **Purpose.** The purpose of this Article is to provide Participants an opportunity to make pre-tax payments for the cost of Group Vision Coverage through this Plan. The Employer provides Group Vision Coverage through one or more "plans" within the meaning of Sections 105 and 106 of the Code.

11.3 **Definitions.**

(a) **Dependent** means an individual (e.g., Spouse, child, domestic partner, etc.) who qualifies as a "dependent" under the terms and conditions of the applicable plan document governing the Group Vision Coverage.

(b) **Group Vision Coverage** means the vision coverage made available by the Employer to which the Insurance Premiums relate. It does not include individual insurance policies.

(c) **Highly Compensated Individual** means an individual who is highly compensated as defined in Section 105(h)(5) of the Code.

(d) **Insurance Contract** means (1) any insurance contract secured from an Insurer authorized to do business in the state in which such contract is issued, which has been obtained for the purpose of providing Group Vision Coverage; or (2) a self-insured plan administered by a third party providing Group Vision Coverage.

(e) **Insurance Premiums** means the amount that must be paid on a periodic basis in return for coverage under the Insurance Contract, which may include premiums for continuation coverage provided under applicable federal or state law.

11.4 **Terms, Conditions and Limitations.** The Employer shall secure the necessary Insurance Contracts for the provision of Group Vision Coverage. Coverage under the Group Vision Coverage shall begin, benefits shall be provided, and coverage shall terminate in accordance with the applicable Insurance Contracts. Such Insurance Contracts are expressly incorporated into and made part of this Plan and identified in Exhibit B.

11.5 **Payments.** The Plan Administrator shall make Insurance Premium payments for the Group Vision Coverage on behalf of the Participant in an amount necessary to provide the benefit applicable to the Participant under this portion of the Plan for the applicable Plan Year. Such payments shall be made from Employer Contributions, if any, provided by the Employer under the Plan and, if necessary, contributions made in accordance with the salary reduction arrangement and other arrangements applicable to the Participant under the terms of the Plan. The appropriate portions shall depend on the coverage elected by the Participant. The Plan Administrator shall also make such payments on behalf of the Participant's Dependents who are enrolled in the Group Vision Coverage. To the extent a Dependent is provided coverage under the Group Vision Coverage and that Dependent is not the Participant's Spouse or Tax Dependent, the tax consequence of such coverage shall be addressed as described in Section 4.3.

11.6 **Nondiscrimination.** To the extent, he Group Vision Coverage is subject to Section 105(h) of the Code, it shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate or benefits. If the Plan Administrator determines that this portion of the Plan is or may be discriminatory, the Plan Administrator may take action permitted by law to avoid such a result as described in Section 6.16.

11.7 **Medical Child Support.**

(a) **Plans Subject to ERISA.** Notwithstanding any provision of this Plan to the contrary, the Plan shall recognize Qualified Medical Child Support Orders ("QMCSOs”) regarding the Group Vision Coverage to the extent required by applicable law.

(b) **Plans Not Subject to ERISA**. Notwithstanding any provision of this Plan to the contrary, the Plan shall recognize medical child support orders regarding the Group Vision Coverage to the extent required by applicable law.

11.8 **Continuation of Coverage.** Continued coverage under the Group Vision Coverage shall be provided if it is required under, and in accordance with, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended. The Plan Administrator may, within the parameters of the law, establish uniform policies by which to provide such continuation coverage. There shall also be compliance with state laws concerning continuation of vision benefit coverage to the extent not preempted by federal law.

11.9 **HIPAA.** The Group Vision Coverage shall comply with the Privacy Rules and Security Rules under HIPAA (if applicable) as further provided in the Insurance Contract and/or the HIPAA policies established by the "covered entity" (as that term is defined in HIPAA).

ARTICLE XII.
GROUP TERM LIFE COVERAGE AND/OR GROUP AD&D COVERAGE

12.1 **Separate Written Plan.** For purposes of Sections 79, 105 and 106 of the Code, this Article shall constitute a separate written plan providing for the payment of Insurance Premiums. To the extent necessary, other provisions of the Plan are incorporated by reference in this document.

12.2 **Purpose.** The purpose of this Article is to provide Participants an opportunity to make pre-tax or post-tax elections (as applicable according to the terms of the Component Benefit) payments for the cost of Group Term Life Coverage and/or Group Accidental Death & Dismemberment ("AD&D") Coverage through this Plan. The Employer provides Group Term Life Coverage and/or Group AD&D Coverage through one or more "plans" within the meaning of Sections 79, 105, and 106 of the Code.

Note: This Article does not permit pre-tax payment of Insurance Premiums for coverage other than Participant coverage (i.e., premiums for spousal or dependent coverage cannot be paid through the Plan).

12.3 **Definitions.**

(a) **Group AD&D Coverage** means the accidental death and dismemberment insurance coverage made available by the Employer to which the Insurance Premiums relate. It does not include individual insurance policies.

(b) **Group Term Life Coverage** means the group term life insurance coverage made available by the Employer to which the Insurance Premiums relate. It does not include individual insurance policies.

(c) **Insurance Contract** means any insurance contract secured from an Insurer authorized to do business in the state in which such contract is issued that has been obtained for the purpose of providing Group Term Life Coverage and/or Group AD&D Coverage.

(d) **Insurance Premiums** means the amount that must be paid on a periodic basis in return for group coverage under the Insurance Contract(s).

12.4 **Terms, Conditions and Limitations.** The Employer shall secure the necessary Insurance Contracts for the provision of Group Term Life and AD&D Coverage. Coverage under the Group Term Life Coverage and/or Group AD&D Coverage shall begin, benefits shall be provided, and coverage shall terminate in accordance with the applicable Insurance Contracts. Such Insurance Contracts are expressly incorporated into and made part of this Plan as identified in Exhibit B.

12.5 **Payments.** The Plan Administrator shall make Insurance Premium payments for the Group Term Life Coverage and/or Group AD&D Coverage on behalf of the Participant in an amount necessary to provide the benefit applicable to the Participant under this portion of the Plan for the applicable Plan Year. Such payments shall be made from Employer Contributions, if any, provided by the Employer under this portion of the Plan and, if necessary, contributions made in accordance with the salary reduction arrangement and other arrangements applicable to the Participant under the terms of the Plan. The appropriate portions shall depend on the coverage elected by the Participant.

12.6 **Nondiscrimination.** To the extent the Group Term Life Coverage is subject to Section 79(d) of the Code, it shall not discriminate in favor of Key Employees as to eligibility to participate or benefits. If the Plan Administrator determines that the Group Term Life Coverage is or may be discriminatory, the Plan Administrator may take any action permitted by law to avoid such result as described in Section 6.16.

12.7 **Limitation on Group Term Life Coverage.** The cost of Group Term Life Coverage on the Participant's life paid by the Employer shall not be included in the Participant's gross income to the extent the face amount of the Insurance Contract(s) does not exceed $50,000 except as provided in Section 15.6. If the face amount of the Insurance Contract(s) paid by the Employer exceeds $50,000, the cost of the coverage in excess of $50,000 shall be imputed to the Participant as income in accordance with Section 79 of the Code and the Cafeteria Plan Regulations. For purposes of this limitation, coverage paid by the Employer, whether inside or outside this plan, on a tax-favored basis without imputation of income to the Employee is considered "paid by the Employer," and coverage paid by the Participant on a pre-tax basis is considered "paid by the Employer." Under no circumstances shall the coverage on the life of persons covered through the Participant (e.g., Spouse, children) be paid through this Plan.

12.8 **Tax Consequences of AD&D Coverage.** It is intended that the Insurance Premiums paid by the Employer (including pre-tax payments paid by the Participant through this portion of the Plan) for a Participant's Group AD&D Coverage shall be excluded in the Participant's gross income under Section 106 of the Code. Any benefits received under an Insurance Contract purchased under this portion of the Plan shall be excluded from the recipient's gross income to the fullest extent allowed by law.

12.9 **Continuation/Conversion of Coverage.** The Group Term Life Coverage shall comply with applicable state law regarding continuation of coverage and conversion of coverage to the extent such state law is not preempted by federal law. In addition, any continuation and conversion rights provided under the terms of the Insurance Contract(s) through which benefits are provided shall be available to the extent they are not prohibited or preempted by federal law.

ARTICLE XIII.
GROUP DISABILITY COVERAGE

13.1 **Separate Written Plan.** For purposes of Sections 105 and 106 of the Code, this Article shall constitute a separate written plan providing for the direct payment of Insurance Premiums. To the extent necessary, other provisions of the Plan are incorporated by reference.

13.2 **Purpose.** The purpose of this Article is to provide Participants the opportunity to make pre-tax or post-tax elections (as applicable according to the terms of the Component Benefit) payments for the cost of Group Disability Coverage through this Plan . The Employer provides Group Disability Coverage through one or more "plans" within the meaning of Sections 105 and 106 of the Code.

> **NOTE:** This Article does not permit pre-tax payments of Insurance Premiums for coverage other than Participant coverage (i.e., premiums for spousal or dependent coverage cannot be made through the Plan).

13.3 **Definitions.**

(a) **Group Disability Coverage** means the long term disability coverage and/or short term disability coverage made available by the Employer to which the Insurance Premiums relate. It does not include individual disability insurance contracts.

(b) **Insurance Contract** means (1) any group insurance contract secured from an Insurer authorized to do business in the state in which such contract is issued, or (2) a self-insured plan established by the Employer for the purpose of providing Group Disability Coverage to its employees.

(c) **Insurance Premiums** means the amount that must be paid on a periodic basis in return for coverage under the Insurance Contract.

13.4 **Terms, Conditions and Limitations.** The Employer shall secure the necessary Insurance Contracts for the provision of Group Disability Coverage. Coverage under the Group Disability Coverage shall begin, benefits shall be provided, and coverage shall terminate in accordance with the applicable Insurance Contracts. Such Insurance Contracts are expressly incorporated into and made part of this Plan as identified in Exhibit B.

13.5 **Payments.** The Plan Administrator shall make Insurance Premium payments for the Group Disability Coverage on behalf of the Participant in an amount necessary to provide the benefit applicable to the Participant under this portion of the Plan for the applicable Plan Year. Such payments shall be made from Employer Contributions and, if necessary, contributions made in accordance with the salary reduction or deduction arrangements applicable to the Participant under the terms of the Plan. The appropriate portions shall depend on the coverage elected by the Participant.

13.6 **Tax Consequences.** The tax consequences to the Participant depends on how the premiums for the coverage are paid, as selected in Exhibit A:

(a) **Pre-Tax Premiums.** The premiums paid by the Participant through this portion of the Plan (including by allocation of Employer Contributions, if any) for a Participant's Group Disability Coverage shall be excluded from the Participant's gross income under Section 106 of the Code, in which case any benefits received under the Group Disability Coverage shall be included in the recipient's gross income to the extent required under applicable provision(s) of the Code; or

(b) **After-Tax Premiums.** The premiums paid by the Participant through this portion of the Plan (including by allocation of Employer Contributions, if any) for a Participant's Group Disability Coverage shall be included in the Participant's gross income, in which case any benefits received under the Group Disability Coverage shall be excluded from the recipient's gross income to the fullest extent allowed under applicable provision(s) of the Code.

13.7 **Continuation/Conversion of Coverage.** There shall be compliance with applicable state law regarding continuation of coverage and conversion of coverage to the extent such state law is not preempted by federal law. In addition, any continuation and conversion rights provided under the terms of the Insurance Contract(s) through which benefits are provided shall be available to the extent they are not prohibited or preempted by federal law.

ARTICLE XIV.
HSA CONTRIBUTION FEATURE

14.1 **Separate Written Plan.** For purposes of Section 223 of the Code, this Article shall constitute a separate written plan. To the extent necessary, other provisions of the Plan are incorporated by reference. This HSA Contribution Feature and the underlying HSAs are not subject to ERISA.

14.2 **Purpose.** The purpose of this Article is to provide Participants an opportunity to make HSA contributions through this Plan.

14.3 **Definitions.**

(a) **HSA** means a health savings accounts under Code Section 223 established and owned by a Participant to which contributions are made under this portion of the Plan. The Employer does not sponsor a Participant's HSA and a Participant's HSA is not an employer-sponsored group health plan. Unless indicated otherwise in Exhibit A, for administrative convenience, an HSA must be established only at the trustee/custodian selected by the Employer and as identified in Exhibit B.

(b) **HSA Contribution Feature** means the portion of the Plan described in this Article, which consists of contributions to a Participant's HSA through salary reduction and Employer Contributions, if any.

(c) **High Deductible Health Plan** means, unless otherwise specified in Exhibit A, a "qualifying high deductible health plan" under Section 223(c)(2) of the Code sponsored by the Employer.

(d) **Permitted Insurance or Permitted Coverage** means:

(1) Insurance in which substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities related to ownership or use of property, or similar liabilities as specified by the IRS;

(2) Insurance for specified disease or illness (e.g., cancer insurance);

(3) Insurance that pays a fixed amount per day (or other period) of hospitalization (e.g., hospital indemnity insurance);

(4) Coverage for accidents, disability, dental care, vision care, preventative care, or long-term care;

(5) Some medical reimbursement accounts and health reimbursement arrangements ("HRAs") (e.g., limited scope medical reimbursement accounts and HRAs, suspended HRAs, post-deductible medical reimbursement accounts and HRAs, and retirement HRAs); and

(6) Some wellness programs and employee assistance programs (e.g., those that do not provide significant benefits in the nature of non-preventative medical care or treatment).

14.4 **Eligibility for HSA Contributions.** To be eligible to participate in the HSA Contribution Feature, the Employee must:

(a) Be eligible to participate in this Plan under Section 3.1;

(b) Be covered by the High Deductible Health Plan;

(c) Not have any health coverage through the Employer other than Permitted Insurance, Permitted Coverage, or coverage under the High Deductible Health Plan; and

(d) If provided in Exhibit A, certify to the Plan Administrator (on a form provided by the Plan Administrator) that he/she is eligible to make contributions to an HSA upon the Participant's initial Election to participate in the HSA Contribution Feature and periodically thereafter as requested by the Plan Administrator.

14.5 **Contributions.**

(a) **Employer Contributions.** Employer Contributions, if any, will be contributed to the Participant's HSA at the times established by the Employer.

(b) **Employee Contributions.** Amounts withheld from a Participant's Compensation pursuant to an agreement authorizing salary reduction with respect to this Component Benefit shall be contributed to the Participant's HSA as soon as administratively feasible.

14.6 **Limits on Contributions.** Except as otherwise provided in Exhibit A, the maximum contribution a Participant may make through this HSA Contribution Feature shall be determined in accordance with the following rules:

(a) **General Limit.** During a taxable year, contributions to the HSA may not exceed the statutory indexed amount applicable under Code § 223.

(b) **Catch Up Contributions.** An additional "catch-up" amount (determined on a monthly basis) can be contributed for eligible individuals who attain age 55 before the close of the taxable year.

(c) **Pro-rated limit if Not Eligible on December 1st.** If a Participant ceases to satisfy the eligibility requirements described in Section 19.4 prior to December 1st of any calendar year, the contribution limit for that year shall be determined by multiplying 1/12 of the applicable limit by the number of months the first day of which the Participant had satisfied the eligibility requirements described in Section 19.4. The Employer shall not be required to take an corrective action in the event the amount of HSA contributions made by the Participant prior to the date on which he/she ceased to satisfy the eligibility requirements described in Section 19.4 exceed the pro-rated limit described herein (as adjusted under paragraph (e)).

(d) **Special Rule if Eligible on December 1st.** If a Participant becomes eligible to make contributions under this HSA Contribution Feature (as provided in Section 19.4) during the taxable year and is eligible on December of such year, the Participant shall be deemed to have been eligible for each month in such taxable year and may make HSA contributions up to the full annual limit. This special rule applies to all contributions made during the applicable taxable year, including contributions made prior to or after December 1st.

Example: An Eligible Employee becomes eligible for HSA contributions on July 1st and remains eligible through December 1st. The Eligible Employee may begin making contributions to his or her HSA through this Plan on July 1st at a rate pursuant to which the full annual contribution will have been made by the end of the taxable year.

(e) **Employer Contributions.** The applicable limit on Participant contributions, as determined in accordance with the above-described rules, shall be reduced by the amount of contributions made by the Employer to the Participant's HSA.

14.7 **Investment of HSA Funds.** A Participant may invest his or her HSA funds as allowed by the HSA trustee/custodian. The Employer shall have no control or responsibility for how a Participant's HSA funds are invested.

14.8 **Tax Consequences.** It is intended that the HSA contributions made under this Plan shall be excluded from the Participant's gross income under Section 106 of the Code.

14.9 **Distribution of HSA Funds.** The Employer shall have no responsibility or control over distributions made from a Participant's HSA. The Employer shall have no responsibility to substantiate expenses for which such distributions are made. Sections 6.7 and 6.8 of this Plan shall not apply to distributions from a Participant's HSA. An individual need not be a Participant in this Plan, be covered by the Employer's High Deductible Health Plan, nor be covered by any qualified high deductible health plan in order to receive a distribution from the Participant's HSA.

14.10 **Reporting.** The Employer shall be responsible for reporting contributions made to a Participant's HSA through this Plan on the Participant's Form W-2. Participants shall be responsible for reporting contributions to their HSAs and distributions from their HSAs on appropriate forms. Participants shall also be responsible for determining whether an HSA distribution is taxable.

14.11 **Continuation of Coverage.** This HSA Contribution Feature and the underlying HSAs are not group health plans for purposes of the Consolidated Omnibus Budget Reconciliation Act of 1985, ("COBRA"), as amended, and reflected in the Public Health Services Act ("PHSA"), as amended, the Family and Medical Leave Act ("FMLA"), and the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). COBRA, FMLA, and USERRA do not apply to this HSA Contribution Feature and the underlying HSAs.

14.12 **ERISA.** This HSA Contribution Feature and the underlying HSAs are not subject to ERISA.

ARTICLE XV.
HIPAA PROVISIONS

This Article applies to the Component Benefits provided through this Plan, unless: (1) such Component Benefits are self-insured, have less than fifty (50) Participants, and the Employer is the Claims Administrator; (2) such Component Benefit is not a group health plan subject to HIPAA Privacy and Security Rules; or (3) such Component Benefit contains its own HIPAA Privacy and Security compliance features.

15.1 **Use and Disclosure of PHI.** The Plan will use PHI to the extent allowed by, and in accordance with the uses and disclosures permitted by, HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations. The Plan will also use and disclose PHI as required by law and as permitted by authorization of the subject of PHI. If the Plan discloses PHI to the Employer in accordance with this Article the Employer may use and further disclosure PHI for the same purposes and in the same situations as the Plan may use and disclose PHI, provided that such use or disclosure is for Plan administration functions performed by the Employer for the Plan or is required by law or permitted by authorization. All uses and disclosures of PHI, whether by the Plan or by Employer, shall be limited to the minimum PHI necessary to accomplish the intended purpose of the use or disclosure in accordance with HIPAA. Notwithstanding the foregoing, neither the Plan nor the Employer shall use PHI that is genetic information in a manner that is prohibited by the Genetic Information Nondiscrimination Act of 2008.

(a) **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(1) Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);

(2) Coordination of benefits;

(3) Adjudication of health benefits claims (including appeals and other payment disputes);

(4) Subrogation of health benefit claims;

(5) Establishing employee contributions;

(6) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(7) Billing, collection activities, and related health care data processing;

(8) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

(9) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(10) Medical necessity reviews or reviews of appropriateness of care or justification of charges;

(11) Utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;

(12) Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of provider and/or health Plan); and

(13) Reimbursement to the Plan.

(b) **Health care operations** include, but are not limited to, the following activities:

(1) Quality assessment;

(2) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(3) Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(4) Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

(5) Conducting or arranging for medical review, legal services and auditing function, including fraud and abuse detection and compliance programs;

(6) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(7) Business management and general administration activities of the Plan, including, but not limited to:

(i) Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

(ii) Customer service, including data analyses for policyholders.

(8) Resolution of internal grievances; and

(9) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity under HIPAA or following completion of the sale or transfer, will become a covered entity.

15.2 **Employer's Obligations under the Privacy Rules.** Under the Privacy Rules, the Plan may not disclose PHI to the Employer unless the Employer certifies that the Plan document has been amended to provide that the Plan will make such disclosures only upon receipt of a certification from the Employer that the Plan has been amended to include certain conditions to the Employer's receipt of PHI and that Employer agrees to those conditions. By adopting this Plan document, the Employer certifies that the Plan has been amended as required by the Privacy Rules and that it agrees to the following conditions, thereby allowing the Plan to disclose PHI to the Employer. The Employer agrees to:

(a) Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom the Plan provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(c) Not use or disclose PHI for employment related actions and decisions unless authorized by an individual;

(d) Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;

(e) Report to the Plan any PHI use or disclosure of which it becomes aware that is inconsistent with the uses or disclosures permitted hereunder and/or may constitute a "breach" as that term is defined in HIPAA;

(f) Make PHI available for access by the individual who is the subject of the PHI in accordance with HIPAA;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) Make available the information required to provide an accounting of disclosures in accordance with HIPAA;

(i) Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

(j) If feasible, return or destroy all PHI received for the Plan that the Employer still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

15.3 **Employer's Obligations under Security Rules.** If the Employer creates, receives, maintains, or transmits ePHI (other than enrollment and disenrollment information and Summary Health Information, which are not subject to these restrictions), the Employer will:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI;

(b) Ensure that any agents, including subcontractors, who create, receive, maintain, or transmit ePHI on behalf of the Plan implement reasonable and appropriate security measures to protect the ePHI;

(c) Report to the Plan any Security Incident of which it becomes aware; and

(d) Implement reasonable and appropriate security measures to ensure that only those persons identified below have access to ePHI and that such access is limited to the purposes identified below.

15.4 **Adequate separation between the Plan and the Employer must be maintained.** In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

(a) The person employed in the position that is given primary responsibility for performing the Employer's duties as the Plan Administrator of the Component Benefits; and

(b) Staff designated by the person described in (a) above.

15.5 **Limitation of PHI Access and Disclosure.** The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Employer performs for the Plan.

15.6 **Noncompliance Issues.** If a person described above does not comply with this Plan document, the Employer shall provide a mechanism for resolving issues of noncompliance including, but not limited to, disciplinary sanctions.

ARTICLE XVI.
COBRA PROCEDURES

This Article applies to the Component Benefits provided through this Plan, unless: (1) such Component Benefit is not a group health plan subject to COBRA; or (2) such Component Benefit contains its own COBRA compliance features.

16.1 **COBRA Notification Procedures.** The following notification procedures apply to Component Benefits that are group health plans other than the Component Benefits described in Section 22.1. Such plans are collectively referred to herein as the "Health Plan(s)."

(a) **Notice of qualifying event.** Under the law, a Covered Individual (or a representative acting on behalf of the Covered Individual) has the responsibility to inform the Health Plans of a divorce, legal separation, or a child losing Dependent status under the Health Plans (the "qualifying event") within sixty (60) days of the latest of: (1) the date of the qualifying event; (2) the date coverage would be lost because of the qualifying event; or (3) the date on which the Covered Individual was informed of the responsibility to provide notice and the procedures for doing so. The notification must be provided in writing and be mailed to the Health Plans. Oral notification, including notification by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notifications are not acceptable. The notification must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:

(1) State the name of the Health Plan;

(2) State the name and address of the employee or former employee who is or was covered under the Health Plan;

(3) State the name(s) and address(es) of all Covered Individuals who lost coverage due to the qualifying event;

(4) Include a detailed description of the event;

(5) Identify the effective date of the event; and

(6) Be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

If no notification is received within the required time period, no continuation coverage will be provided. If the notification is incomplete, it will be deemed timely if the Health Plans are able to determine the Health Plan to which it applies, the identity of the employee and the Covered Individuals, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no continuation coverage will be provided.

ARTICLE XVII. PANDEMIC RELATED PLAN PROVISIONS

Extension of Certain Timeframes due to the COVID-19 Emergency
Effective Date: February 26, 2021

The US Department of Labor announced that, due to the ongoing national emergency caused by the COVID-19 outbreak, certain timeframes required under ERISA and the IRS have been extended. Specifically, applicable deadlines that fall within the Outbreak Period are extended until the earlier of: (i) the one-year anniversary of the otherwise applicable deadline, or (ii) the end of the Outbreak Period. This applies to deadlines applicable to individuals participating in the plan, as well as deadlines applicable to the plan and plan administrators. The deadline extension period is determined on an individual-by-individual or case-by-case basis.

The actual date the compliance timeframe resumes will depend on the date the National Emergency is declared to be over by the Federal Government.

The timeframes for the following plan conditions are extended by this Final Rule:

- HIPAA Special Enrollment Periods ("COBRA Qualifying Events")
- COBRA Election periods
- The date for making COBRA premium payments
- The date for qualified beneficiaries to notify the COBRA administrator of a qualifying event or a determination of disability
- The date for filing a benefits claim
- The date for filing an appeal of an adverse benefit determination
- The date for requesting an external review of an adverse benefit determination
- The date for filing a corrected request for external review, in the event the initial request was incomplete.

EXHIBIT A:

EMPLOYER AND PLAN INFORMATION

Name of Plan:	King George, LLC Cafeteria Plan
Effective Date:	January 1, 2024
Effective Date of Original Plan:	January 1, 2017
Employer:	King George, LLC 320 Hemphill Street Fort Worth, TX, 76104 Phone: 817-820-0881
Employer Identification Number:	45-2208512
Organization Type:	Corporation
Employer Subject to ERISA:	Yes
Plan Administrator:	King George, LLC 320 Hemphill Street Fort Worth, TX 76104 Phone: 817-820-0881
Claims Administrator:	King George, LLC 320 Hemphill Street Fort Worth, TX 76104 Phone: 817-820-0881
Agent for Service of Legal Process:	King George, LLC 320 Hemphill Street Fort Worth, TX 76104 Phone: 817-820-0881 Legal process may also be served on the Plan Administrator.
Plan Year:	January 1 - December 31
Frequency of Salary Reduction Contributions:	FT Semi-monthly FT Bi-weekly FT Weekly SCA Semi-monthly SCA Bi-weekly SCA Weekly
State of Governing Law:	Texas
Modifications to Irrevocable Election Rules:	None
Top-Paid Group Election:	No
Special Rule - Newly Hired:	No

Cash Out of Employer Contribution:	Not Available
Cash In Lieu of Coverage:	Not Available

Group Disability Coverage - Offered

Type of Benefits:	Both Long Term Disability and Short Term Disability
Tax Consequence:	Insurance Premiums Paid Post-Tax

HSA Contribution Feature - Offered

HSA Trustee/Custodian:	Selected by Employer
High Deductible Health Plan Means:	HDHP(s) sponsored by Employer
Certification of HSA Eligibility:	Not Required
Limits on Contributions:	Statutory Limit

EXHIBIT B:

COMPONENT BENEFIT(S)

Component Benefit(s) consist of the following:

Group Medical Coverage

Plan Name: PPO Plan

Provider Name: BCBS of Texas

Provider Address: 1001 East Lookout Drive, Richardson, TX, 75082

Provider Phone: 800-521-2227

ERISA Plan Number: 503

Eligibility: Full Time employees working 30 hours per week

Waiting Period: First of the month following date of hire

Funding: Fully Insured

Election Type: Affirmative

Employer Contribution: Available

Plan Name: PPO HDHP

Provider Name: BCBS of Texas

Provider Address: 1001 East Lookout Drive, Richardson, TX, 75082

Provider Phone: 800-521-2227

ERISA Plan Number: 503

Eligibility: Full Time employees working 30 hours per week

Waiting Period: First of the month following date of hire

Funding: Fully Insured

Election Type: Affirmative

Employer Contribution: Available

Plan Name: Simnsa Health Plan

Provider Name: Simnsa Health Plan

Provider Address: 2088 Otay Lakes Road, #102, Chula Vista, CA 91913

Provider Phone: 619-407-4082

ERISA Plan Number: 503

Eligibility: Full Time employees working 30 hours per week

Waiting Period: First of the month following date of hire

Funding: Fully Insured

Election Type: Affirmative

Employer Contribution: Not Available

Plan Name: TRICARE Military Veteran's Benefit

Provider Name: TriCare/Selman & Company

Provider Address: 1 Integrity Pkwy., Highland Heights, OH, 44143

Provider Phone: 800-638-2610

Eligibility: Full Time employees working 30 hours per week

Waiting Period: First of the month following date of hire

Election Type: Affirmative

Employer Contribution: Not Available

Group Dental Coverage

Plan Name: Dental PPO

Provider Name: BCBS of Texas

Provider Address: 1001 East Lookout Drive, Richardson, TX, 75082

Provider Phone: 800-521-2227

ERISA Plan Number: 503

Eligibility: Full Time employees working 30 hours per week

Waiting Period: First of the month following date of hire

Election Type: Affirmative

Employer Contribution: Available

Group Vision Coverage

Plan Name: Vision

Provider Name: BCBS of Texas

Provider Address: 1001 East Lookout Drive, Richardson, TX, 75082

Provider Phone: 800-521-2227

ERISA Plan Number: 503

Eligibility: Full Time employees working 30 hours per week

Waiting Period: First of the month following date of hire

Election Type: Affirmative

Group Disability Coverage

Plan Name: Short-Term Disability

Provider Name: Unum Life Insurance Company

Provider Address: 1 Fountain Square, Chattanooga, TN, 37402

Provider Phone: 800-421-0344

Eligibility: Full Time employees working 30 hours per week

Waiting Period: First of the month following date of hire

Election Type: Affirmative

Employer Contribution: Not Available

Plan Name: Long-Term Disability

Provider Name: Unum Life Insurance Company

Provider Address: 1 Fountain Square, Chattanooga, TN, 37402

Provider Phone: 800-421-0344

Eligibility: Full Time employees working 30 hours per week

Waiting Period: First of the month following date of hire

Election Type: Affirmative

Employer Contribution: Not Available

Group Life/AD&D

Plan Name: Employer Paid Life/AD&D

Provider Name: Unum Life Insurance Company

Provider Address: 1 Fountain Square, Chattanooga, TN, 37402

Provider Phone: 800-421-0344

Eligibility: Full Time employees working 30 hours per week

Waiting Period: First of the month following date of hire

Election Type: Rolling

Employer Contribution: Available

Supplemental Life/AD&D

Plan Name: Voluntary Life/AD&D

Provider Name: Unum Life Insurance Company

Provider Address: 1 Fountain Square, Chattanooga, TN, 37402

Provider Phone: 800-421-0344

Eligibility: Full Time employees working 30 hours per week

Waiting Period: First of the month following date of hire

Election Type: Affirmative

Employer Contribution: Not Available

HSA Contribution Feature

Plan Name: HSA

Trustee/Custodian Name: HSA Bank

Trustee/Custodian Address: PO Box 989, Sheboygan, WI, 53082

Trustee/Custodian Phone: 866-357-5232

Eligibility: Full Time employees working 30 hours per week

Waiting Period: First of the month following date of hire

Election Type: Affirmative

Employer Contribution: Not Available

Wellness Program-Available to Employees Enrolled in the Medical Plan

Plan Name: Employee Wellness Program

Provider Name: King George, LLC

Provider Address: 320 Hemphill St., Fort Worth, TX, 76104

Provider Phone: 817-820-0881

Eligibility: Full Time employees working 30 hours per week

Waiting Period: First of the month following date of hire

Election Type: N/A

Employer Contribution: Available

Worksite Benefits

Plan Name: Critical Illness

Provider Name: Unum Life Insurance Company

Provider Address: 1 Fountain Square, Chattanooga, TN, 37402

Provider Phone: 800-421-0344

Eligibility: Full Time employees working 30 hours per week

Waiting Period: First of the month following date of hire

Election Type: Affirmative

Employer Contribution: Not Available

Plan Name: Accident

Provider Name: Unum Life Insurance Company

Provider Address: 1 Fountain Square, Chattanooga, TN, 37402

Provider Phone: 800-421-0344

Eligibility: Full Time employees working 30 hours per week

Waiting Period: First of the month following date of hire

Election Type: Affirmative

Employer Contribution: Not Available

Plan Name: Hospital Indemnity

Provider Name: Unum Life Insurance Company

Provider Address: 1 Fountain Square, Chattanooga, TN, 37402

Provider Phone: 800-421-0344

Eligibility: Full Time employees working 30 hours per week

Waiting Period: First of the month following date of hire

Election Type: Affirmative

Employer Contribution: Not Available

Employee Assistance Program (EAP)

Plan Name: EAP

Provider Name: Unum Life Insurance Company

Provider Address: 1 Fountain Square, Chattanooga, TN, 37402

Provider Phone: 800-421-0344

Eligibility: Full Time employees working 30 hours per week

Waiting Period: First of the month following date of hire

Election Type: Affirmative

Employer Contribution: Not Available

Additional Benefit

Plan Name: Benefits Boost Program

Provider Name: MyBenefitsWork

Provider Address: 14240 Proton Rd., Dallas, TX, 75244

Provider Phone: 800-800-8304

Eligibility: Full Time employees working 30 hours per week

Waiting Period: First of the month following date of hire

Election Type: Affirmative

Employer Contribution: Not Available