King George, LLC
CAFETERIA PLAN
SUMMARY PLAN DESCRIPTION

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PART I.
GENERAL INFORMATION ABOUT THE PLAN

1.1 What is the purpose of the Cafeteria Plan?

The purpose of the Cafeteria Plan is to allow certain Employees to use funds provided through Employee salary reduction and Employer Contributions, if any, to choose (and pay for) certain benefits made available by the Employer through the Cafeteria Plan.

1.2 When does the Cafeteria Plan take effect?

The Cafeteria Plan was originally effective January 1, 2017. This restatement is effective January 1, 2024. The Cafeteria Plan operates on a Plan Year running from January 1 through December 31.

1.3 What Benefits are offered through the Cafeteria Plan?

The Component Benefits available through this Plan are identified in Exhibit B.

NOTE: The Component Benefits listed in Exhibit B are the only Component Benefits available through this Cafeteria Plan. Any references to benefits not identified as Component Benefits on Exhibit B should be disregarded.

1.4 Who can participate in the Cafeteria Plan?

Employees who meet the requirements in Exhibit B are called "Eligible Employees." Those Eligible Employees who actually participate in the Cafeteria Plan are called "Participants." There are certain exceptions. They are described in the underlying Cafeteria Plan document. You will be notified if you fall within one of the exceptions.

If you are a Participant, the Cafeteria Plan allows you to pay your share of the cost of the Component Benefits available through this Cafeteria Plan on a pre-tax basis. Participation in the Cafeteria Plan is tied to you being actually covered under one or more Component Benefits. An Employee covered under one or more of the Component Benefits available through this Cafeteria Plan can also participate in this Cafeteria Plan. As a condition of participation in the Cafeteria Plan, you must observe all Cafeteria Plan rules and regulations.

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

1.5 When does my participation in the Cafeteria Plan begin?

For newly Eligible Employees, participation may begin on, or closely following, the date on which you satisfy the definition of Eligible Employee. If they are required, you must submit the enrollment forms within the time period established and communicated to you by the Plan Administrator.

> **NOTE:** With respect to Component Benefits involving premiums for group coverage, if you have enrolled in those benefits, you may automatically become a Participant in this Cafeteria Plan as described in Section 1.6.

If you do not become a Participant when first eligible, you may become a Participant at the start of any subsequent Plan Year.

As a condition to participation in the Cafeteria Plan, you must also:

(a) Observe all Plan rules and regulations;

(b) Agree to inquiries by the Plan Administrator with respect to any physician, hospital, or other provider of medical care or other services covered by Component Benefits available through this Cafeteria Plan;

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

(d) Agree to repay any overpayments or incorrect payments you receive from the Cafeteria Plan.

Participation continues until you elect not to participate, you are no longer an Eligible Employee, the Cafeteria Plan terminates, you are no longer covered under any Component Benefits, your contributions cease, or your participation is terminated for cause.

1.6 How do I enroll and make benefit elections?

(a) **Generally.** The Plan Administrator will provide you with the means necessary to enroll and make elections, including information about the costs of the various Component Benefits.

(b) **Initial Enrollment**. If you become an Eligible Employee other than at the start of a Plan Year, the initial enrollment period takes place at the time you become eligible to participate as described in Section 1.5. To the extent you have enrolled in the Group Medical Coverage, Group Dental Coverage, Group Vision Coverage, Group Disability Coverage, or Group Term Life and AD&D Benefits, you will be deemed to have elected to participate in the Cafeteria Plan for purposes of paying your share of the premium responsibility on a pre-tax basis through salary reduction (unless otherwise required by the plan to be paid post-tax). This will occur unless you specifically elect not to participate with respect to such coverage. The reimbursement-type Component Benefits (see Exhibit B) requires an affirmative election. If you do not make an affirmative election with respect to these Component Benefits during the initial enrollment period, you must generally wait until the next open enrollment period to begin participation. Such an election must be in writing and must be received by the Plan Administrator prior to the date your participation in the Cafeteria Plan would otherwise begin. Furthermore, if you fail to make an election, the Employer Contribution, if any, will be handled in accordance with Exhibit A.

(c) **Annual Enrollment**. The annual enrollment period for the coming Plan Year begins and ends on or before the last day of each plan year. If you do not make an election during the annual enrollment period, you will be deemed to have elected to not participate in the Cafeteria Plan. To the extent you continue your enrollment in the Group Medical Coverage, Group Dental Coverage, Group Vision Coverage, Group Disability Coverage, or Group Term Life and AD&D Benefits, you will be deemed to have elected to continue participation in the Cafeteria Plan for purposes of paying your share of the premium responsibility on a pre-tax basis through salary reduction. This will occur unless you specifically elect not to participate with respect to such coverage. The reimbursement-type Component Benefits (see Exhibit B) requires an affirmative election. If you do not make an affirmative election with respect to these Component Benefits during the initial enrollment period, you must generally wait until the next open enrollment period to begin participation. Such an election must be in writing and must be received by the Plan Administrator prior to the first day of the Plan Year. Furthermore, if you fail to make an election, the Employer Contribution, if any, will be handled in accordance with Exhibit A.

NOTE: ***THE LAW REQUIRES*** that enrollment forms received after the close of the enrollment period shall be void.

CAUTION: With limited exceptions, once made, elections remain in effect for the entire Plan Year. The exceptions are described below at Question 1.8.

1.7 What is the maximum election I can make under the Cafeteria Plan?

The maximum salary reduction election available under this Cafeteria Plan is the sum of your cost of coverage under the available Component Benefits minus any Employer Contribution, if any.

1.8 Can I change my election during the Plan Year?

Generally, you cannot change your election regarding participation in the Cafeteria Plan or the Component Benefits you have selected under the Cafeteria Plan during the Plan Year. You may change your elections only during the annual enrollment period, and then, only for the coming Plan Year. However, your elections will terminate automatically if you cease to be eligible to participate in the Cafeteria Plan. In addition, there are several other exceptions to this general rule.

Caution: The circumstances in which you are allowed to change your election, as further described below, are based upon the facts and circumstances of each particular situation. The descriptions of the rules below are general in nature. If you have questions regarding the application of the rules to your specific fact situation, please contact the Plan Administrator immediately. Any request to change your election must be withing the deadline described below.

NOTE: The exceptions to the general rule that elections are irrevocable for the Plan Year are determined under regulations issued by the IRS.

NOTE: The IRS recognizes only marriages that are valid under applicable state law. Accordingly, a reference to marital status or spouse in this Section 1.8 is applicable only if you are married to an individual and the marriage is valid under applicable state law.

(a) **Change in Status.** You may change or revoke your previous election during the Plan Year if one or more of the following changes in status occur:

(1) A change in your legal marital status or domestic partner status, including marriage, divorce, death of your spouse, legal separation, or annulment;

(2) A change in the number of your dependents, including the birth of a child, adoption or placement for adoption of a dependent, or death of a dependent;

(3) Any of the following events that change your employment status or the employment status of your spouse or dependent: termination or commencement of employment, a reduction or increase in hours worked, a switch between part-time and full-time, a strike of lockout, a change in worksite, commencement or return from an unpaid leave of absence, a switch between hourly and salaried, a switch between union and non-union, or any similar event;

(4) An event causing a dependent to satisfy or cease to satisfy the eligibility requirements applicable under a plan provided or paid for through this Cafeteria Plan; or

(5) A change in place of residence for you, your spouse or your dependent resulting in loss of access of coverage.

A change or revocation shall be allowed in these circumstances only if such change or revocation is made on account of, and corresponds with, the change in status and the change in status affects eligibility for coverage under a plan sponsored by the Employer or another employer (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 or revocation satisfies the general consistency requirement.

A requested change or revocation must also satisfy the following specific consistency requirements for you to be able to alter your election based on the change in status:

(1) **Loss of Dependent Eligibility.** For a change in status involving your divorce, annulment or legal separation from your spouse, the death of your spouse or dependent, or your dependent ceasing to satisfy the eligibility requirements for coverage, you may elect to change your election only to reflect the cancellation of group health plan coverage for the affected spouse or dependent. Cancelling coverage for any other individual under these circumstances fails to correspond with that change in status. For example, if you have elected group medical coverage for you, your spouse, and your child, and you divorce during the Plan Year, you may drop your ex-spouse from the coverage and make an election change under this Cafeteria Plan to reflect the reduced cost of coverage. However, you would not be allowed to change your election to reflect the reduced cost attributable to dropping coverage for yourself or your child.

(2) **Gain of Coverage Eligibility Under Another Employer's Plan.** If you, your spouse, or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital status or a change in employment status, you may elect to terminate or decrease your election under this Cafeteria Plan on account of that change in status only if 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 your legal marital status or the employment status of your spouse

or dependent, you may increase or decrease the amount of your Group Term Life Coverage and/or Group Disability Coverage and change your election under the Cafeteria Plan to pay the increased or decreased cost of such coverage without regard to the requirement that the event cause a loss or gain of eligibility.

(4) **COBRA Coverage.** If you, your spouse, and/or your dependent elects COBRA continuation coverage (or similar health plan continuation coverage under state law) with respect to a group health plan sponsored by the Employer, you may increase your election for the purpose of paying the cost of the increased premium for such continuation coverage, provided you are still eligible under the Cafeteria Plan and are receiving compensation from the Employer.

(b) **Other Change in Election Events.** You may also change or revoke your previous election during the Plan Year in the following circumstances.

(1) **HIPAA Special Enrollment Rights.** In certain cases, individuals are allowed to enroll in the Employer's Group Medical Coverage pursuant to HIPAA special enrollment at times other than open enrollment. Generally, special enrollment is available upon: (i) acquiring a new spouse or dependent, (ii) losing other group coverage, (iii) losing coverage under Medicaid or a state children's health insurance program ("SCHIP"), and (iv) becoming eligible for a subsidy under Medicaid or SCHIP for coverage under the Employer's group health plan. (Please refer to the plan documentation for the Group Medical Coverage for additional information regarding HIPAA special enrollment, including information regarding the situations in which special enrollment is available and the deadline for requesting special enrollment under that plan.)

If you, your spouse, and/or your dependent actually enroll in the Group Medical Coverage pursuant to HIPAA special enrollment, then you may make a new election under the Cafeteria Plan to pay the cost of that new or increased coverage. For purposes of this provision 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.

Note: There are two separate steps involved in making an election change under this exception. You and/or your spouse and dependents must enroll in the Group Medical Coverage within the HIPAA special enrollment time period required under that plan. If such enrollment in the Group Medical Coverage changes your share of the cost of coverage, you must also request a change to your election under the Cafeteria Plan in accordance with paragraph (h) below. The time period described in paragraph (h) begins to run on the effective date of the special enrollment in the Group Medical Coverage. It is the coverage attributable to the HIPAA special enrollment that triggers the need to change election under the Cafeteria Plan.

(2) **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 you to cover your child (including a foster child who is your dependent) under the Group Medical Coverage, Group Dental Coverage, Group Vision Coverage, you may change your election to pay the increased cost of coverage incurred to add the dependent child to your coverage. If an Order requires another individual to

provide health coverage for your child (including a foster child who is your dependent) and the child is currently enrolled in the Group Medical Coverage, Group Dental Coverage, Group Vision Coverage, you may terminate coverage for the child and change your election to reflect the reduced cost of coverage (if any), provided the other individual actually provides coverage to the child as required by the Order. For example, if you have enrolled in single coverage under the Group Medical Coverage, become divorced during the Plan Year, and are ordered to provide coverage to your child following the divorce, you may increase your election to pay the additional cost of the child's coverage under the Group Medical Coverage.

(3) **Medicare and Medicaid.** If you, your spouse, or your dependent is enrolled in the Group Medical Coverage or Group Dental Coverage, Group Vision Coverage, such individual subsequently enrolls in Medicare or Medicaid, and such individual's coverage under the Employer's plan is cancelled, you may change your election to reflect the reduced cost of coverage (if any) under the applicable Employer-sponsored group health plan.

NOTE: Certain changes to an individual's Medicaid coverage also create a HIPAA special enrollment right. Election changes based on HIPAA special enrollment rights are described above.

(c) **Change in Cost**.

(1) **Automatic Increase or Decrease for Insignificant Cost Changes.** If the cost of coverage increases or decreases during a Plan Year by an insignificant amount, then your election to pay the cost of such coverage through the Cafeteria Plan shall be automatically increased or decreased to reflect such change in the cost. 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 the percentage of the cost change).

(2) **Significant Cost Increases.** If the Plan Administrator determines that the cost of coverage significantly increases during a Plan Year, you may either: (i) increase your election to pay the additional cost, (ii) enroll in another benefit package option providing similar coverage and change your election (if necessary) to pay the cost of that option through the Cafeteria Plan, or (iii) cancel the underlying coverage and revoke your election to pay the cost of that coverage through a Cafeteria Plan if no other benefit package option providing similar coverage is available. For example, if the cost of one option under the Group Medical Coverage significantly increases during the Plan Year, you may increase your election to pay the increased cost or enroll in another option available under the Group Medical Coverage and change your election to correspond to the new cost of Group Medical Coverage. If there is only one Group Medical Coverage option, you may increase your election to pay the increased cost of the options or cancel the Group Medical Coverage and revoke your election to pay for that coverage through the Cafeteria Plan. 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 coverage significantly decreases during a Plan Year: (i) you may enroll in the coverage and make or change your election to pay the cost of the coverage through the Cafeteria Plan; or (ii) if you are already enrolled in the underlying coverage and are paying the cost of such coverage through the Cafeteria Plan, the Plan Administrator will automatically decrease your election to pay the cost of such coverage in accordance with the cost decrease.

For purposes of this rule, a change in cost allowing an election change can result from action taken by you (e.g., switching between full-time and part-time employment) or your Employer (e.g., changing the amount of Employer Contribution toward the cost of coverage).

(d) **Change in Coverage**.

(1) **Significant Curtailment.** If the Plan Administrator determines your coverage, or the coverage of your spouse or dependent, is significantly curtailed during a Plan Year, you may enroll in another benefit package option providing similar coverage and make a corresponding election change to pay for that new coverage through the Cafeteria Plan. Coverage is "significantly curtailed" only if there is an overall reduction in coverage provided to participants under the plan so as to constitute reduced coverage to all participants in general (e.g., a significant increase in the

deductible, copays, or out-of-pocket maximum applicable under this plan). The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a benefit package option constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(2) **Loss of Coverage.** If the Plan Administrator determines that your coverage, or the coverage of your spouse or dependent, is lost during a Plan Year, you may (i) enroll in another option providing similar coverage and make a corresponding election change to pay for that new coverage through the Cafeteria Plan, or (ii) if no other option providing similar coverage is available, cancel the underlying coverage and revoke your election to pay the cost of such coverage through this Cafeteria Plan. Coverage is deemed "lost" only if there is a complete loss of coverage (e.g., the benefit plan option is eliminated or an annual or lifetime maximum is reached) or other fundamental loss of coverage (e.g., a substantial decrease in the health care providers available under the option or a reduction in benefits for a specific type of medical condition with respect to which you or your spouse or dependent is currently receiving treatment. 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, a new plan or plan option is offered, or if coverage under an existing plan or option is significantly improved, you may enroll in the new or improved coverage and make or change your election to pay the cost of such coverage through the Cafeteria Plan. 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.** You may make an election change that is on account of and corresponds with a change made under another employer-sponsored plan (including a plan of the Employer of a plan of another employer) if: (i) the other plan permits its participants to make an election change that would be permitted under the prevailing IRS guidance, or (ii) the Plan Year of this Cafeteria Plan is different from the plan year under the other plan. For example, if your spouse drops your coverage during open enrollment under his or her employer's Group Medical Coverage and you enroll in the Employer's Group Medical Coverage, you may make or change your election to pay for such coverage through the Cafeteria Plan.

(5) **Loss of Governmental or Educational Coverage.** If you add coverage under an Employer-sponsored group health plan (e.g., the Group Medical Coverage, Group Dental Coverage, Group Vision Coverage) for yourself or your spouse or dependent because such individual has lost coverage under any health coverage sponsored by a governmental or educational institution (including, but not limited to, the following: a state children's health insurance program ("SCHIP"), a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government health plan), you may make or change your election to pay the cost of such coverage under the Cafeteria Plan.

NOTE: Certain changes to an individual's coverage under a state children's health insurance program ("SCHIP") also create a HIPAA special enrollment right. Election changes based upon HIPAA special enrollment rights are described above.

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

(i) If you have made an election to pay for Group Medical Coverage, you may revoke that election if the following conditions are satisfied:

(A) You either (1) are 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 (2) seek to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period;

(B) You cancel coverage under the Group Medical Coverage in accordance with the requirements of that plan; and

(C) You, 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.

(ii) If you have made an election to pay for Group Medical Coverage, you may reduce that election if the following conditions are satisfied:

(A) Your spouse and/or dependents either (1) 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 (2) seek to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period;

(B) You cancel coverage under the Group Medical Coverage for such spouse and/or dependents in accordance with the requirements of that plan; and

(C) 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.

(e) **Reduction in Hours Without Loss of Eligibility.** If you have made an election to pay for Group Medical Coverage, you may revoke that election if the following conditions are satisfied:

(1) You have been in an employment status under which you were reasonably expected to average at least thirty (30) hours of service per week;

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

(3) You cancel coverage under the Group Medical Coverage in accordance with the requirements of that plan; and

(4) You, 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 your reasonable representation that the requirements of this paragraph (4) are met.

(f) **Family and Medical Leave Act.** If you take a leave governed by the Family and Medical Leave Act of 1993 ("FMLA"), you 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.

(g) **Special Rule for HSA Contribution Feature.** You may change your election with respect to the HSA Contribution Feature prospectively on at least a monthly basis. You may also revoke your election with respect to the HSA Contribution Feature prospectively if you become ineligible to make or have made HSA contributions under the HSA Contribution Feature.

(h) **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, failure to satisfy underwriting). If the Plan Administrator determines before or during any Plan Year the Cafeteria Plan or a Component Benefit may fail to satisfy any nondiscrimination requirement imposed by the Internal Revenue Code or other applicable law, the Plan Administrator may take such action as the Plan Administrator deems appropriate under the rules uniformly applicable to similarly situated Participants, to further compliance with such requirements or limitation. Such action may include, without limitation, a modification of your election downward with or without your consent.

(i) **Procedure for Requesting a Change.** If a change in election is allowed under the rules described above, you must typically inform the Plan Administrator of your new election within thirty (30) days of the occurrence of the event allowing the change unless applicable state law allows a longer election period. Your election change must be on account of and consistent with the status change that has occurred. In general, that means the event must result in a change in coverage that changes the cost. Subject to the provisions of the underlying group health plan, an election made to pay the cost of medical coverage for a newborn or newly adopted dependent child pursuant to HIPAA special enrollment right may be retroactive for up to thirty (30) days, provided it applies

to compensation not yet currently available. 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 foe the balance of the Plan Year in which the election is made unless a subsequent event (described above) allows a further election change.

1.9 Who holds the funds I have set aside under the Cafeteria Plan?

Your salary reduction contributions are held as part of the Employer's general assets until they are used to pay for your benefits. There is no separate trust.

1.10 What happens if I terminate my employment?

If your employment with the Employer terminates during the Plan Year, your active participation with this Cafeteria Plan ceases and your elections are terminated. You will not be able to make any more contributions under this Cafeteria Plan. You may, however, be entitled to continuation coverage with respect to the underlying Component Benefit. See the discussions of continuation coverage later in this summary for additional information.

If you are rehired after thirty (30) days following a termination of employment and again become a Participant, you will have two "periods of coverage" – that period prior to the termination of employment and that period following the re-employment. Expenses incurred prior to the termination of employment shall be subject to the election in effect upon termination. Upon re-employment, you 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.

If you are rehired within thirty (30) days following a termination of employment, your election in effect prior to the termination of employment will be reinstated upon re-employment.

1.11 Will I have any administrative costs under the Cafeteria Plan?

No. The entire cost of administering the Cafeteria Plan is paid by the Employer, from Plan forfeitures, or a combination of both.

1.12 How long will the Cafeteria Plan remain in effect?

Although the Employer expects to maintain the Cafeteria Plan (including each of the Component Benefits) indefinitely, it has the right to amend or terminate the Cafeteria Plan in whole or in part at any time. The Employer does this through an official written action of its governing body. It is also possible that future changes in state or federal tax laws may require that the Cafeteria Plan be amended or terminated accordingly. You will be informed if any changes are made to the Cafeteria Plan.

1.13 Are my benefits taxable?

Because the Cafeteria Plan is intended to meet certain requirements of the federal tax laws, many of the benefits you receive under the Cafeteria Plan will not be currently taxable to you. However, neither the Employer nor the Plan Administrator can guarantee the tax treatment of benefits with respect to any Participant, as individual circumstances may produce differing results. If you are uncertain, you should consult your own tax adviser.

You should realize that any benefits you receive through the Cafeteria Plan (e.g., premium payments, medical expense reimbursements) cannot be claimed as a medical expense deduction on your

income tax return. However, unless your medical expenses exceed seven and one-half percent (7.5%) of your adjusted gross income, you are not permitted to use the deduction anyway.

If you pay the cost of Group Term Life Coverage through this Cafeteria Plan, the cost of some of that coverage may be taxable to you. See the description of Group Term Life and AD&D Coverage later in this Summary for additional information.

If you pay the cost of Group Disability Coverage through this Cafeteria Plan, the cost of all or some of that coverage may be taxable to you depending on how premiums are paid. See the description of Group Disability Coverage later in this Summary for additional information.

Note: If the Plan Administrator determines before or during any Plan Year the Cafeteria Plan may fail to satisfy any nondiscrimination requirement imposed by the Internal Revenue Code, the Plan Administrator may take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to further compliance with such requirements or limitation. Such action may include, without limitation, a re-characterization within the Plan Year of benefits provided under the Cafeteria Plan as taxable income, with or without consent of the affected Participants.

1.14 What is the impact on my Social Security benefits?

Participating in the Cafeteria Plan will reduce the amount of your taxable compensation. Accordingly, your Social Security benefits, which are based upon your taxable compensation, may be affected at your retirement. However, the tax savings you obtain through participation in the Cafeteria Plan often will offset any reduction in your future Social Security benefits.

1.15 What contributions are made to the Cafeteria Plan?

(a) **Employer Contribution.** The Employer may make a fixed dollar contribution per Plan Year, or portion of a Plan Year (e.g., month, pay period), per Participant. The amount of the Employer Contribution may change from year to year as announced by the Employer prior to the Plan Year start. The Employer Contribution must be used in accordance with Exhibit A. The portion of the Employer Contribution not used to pay for benefits shall be forfeited. 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") or other applicable law. Unless indicated otherwise in Exhibit A, 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.

(b) **Salary Reduction Contributions.** To the extent the cost of a Component Benefit exceeds the Employer Contribution (if any), you may elect in accordance with the election procedures described in Section 1.6 to receive your full compensation in cash, or to have a portion of such compensation applied by the Employer toward your share of the cost of Component Benefits. If so elected, your compensation will be reduced, and an amount equal to the reduction will be allocated by the Employer to the Component Benefits you have designated. Your compensation shall be reduced by pro-rata amounts of your 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 every payroll period. Notwithstanding the forgoing, if participation in a Component Benefit extends to the last day of the month in which your employment terminates, if necessary, additional salary reduction contributions shall be taken from your final pay

check to pay for the coverage provided during the period of time following the date on which your employment terminates.

(c) **Salary Deduction Contributions.** Sometimes the Internal Revenue Code or the Cafeteria Plan does not allow payment with pre-tax dollars. Payments which may be made with after-tax dollars may be paid through a salary deduction agreement. A salary deduction provides for a payroll deduction to be made throughout a Plan Year out of your compensation after taxes and withholdings have been made.

1.16 What if coverage is provided to someone other than your spouse and tax dependents?

If you participate in a Component Benefit that covers a dependent who is not your "spouse" or "tax dependent," the entire cost of coverage for Component Benefits for which you are responsible shall be paid pre-tax through this Cafeteria Plan and the fair market value of the coverage for that Dependent shall be imputed as income to you as the coverage is provided. This provision applies regardless of whether the cost of coverage is paid by salary reduction or allocation of available Employer Contributions, if any.

For purposes of this Cafeteria Plan, "spouse" means a person to whom you are legally married in accordance with applicable state law.

For purposes of this Cafeteria Plan, "tax dependent" generally includes an individual who satisfies the requirements of paragraph (a), (b), or (c) below:

(a) an individual who:

(1) Is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption); and

(2) Will not attain age 27 during the relevant calendar year.

(b) an individual who:

(1) Is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption), brother, sister, stepbrother, or stepsister, or a descendant of any such person;

(2) Has the same principal place of abode as you for at least one-half of the relevant year;

(3) Will not attain age 19 (or age 24 if a full time student) during the relevant year or is permanently and totally disabled;

(4) Did not provide over half of his/her own support during the relevant year;

(5) Is a citizen, national, or resident of the United States;

(6) Is younger than you (unless he/she is permanently and totally disabled); and

(7) Does not file a joint tax return with his or her spouse.

(c) an individual who:

(1) Is your child (or a descendant of a child), brother, sister, stepbrother, or stepsister, parent (or a parent's ancestor), stepparent, brother or sister's son or daughter, parent's brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or, if not such relative, an individual who has the same principal place of abode as you and is a member of your household;

(2) Has received more than one-half of his/her support from you during the relevant year;

(3) Is not your qualifying child or the qualifying child of anyone else (i.e., does not satisfy the requirements of paragraph (a) above with respect to any person);

(4) Is a citizen, national, or resident of the United States.

(5) Is your child (son, daughter, stepson, stepdaughter, adopted child, eligible foster child, or child placed for adoption), brother, sister, stepbrother, or stepsister, or a descendant of any such person;

1.17 How are claims determined?

(a) **Administrator.** For purposes of this Section, the Plan Administrator may contract with a third party to perform some or all of the claims determination functions. Where the language refers to the Plan Administrator, the function may be handled by a Claims Administrator. Exhibit A identifies whether there is a Claims Administrator and how to contact that Claims Administrator.

(b) **Claim Submission.** Unless a separate procedure is provided with respect to a Component Benefit, a claim for benefits must be made in writing and submitted to the Plan Administrator. Please refer to the sections of this summary describing each Component Benefit for additional information.

(c) **Benefits Denials.** The Plan Administrator decides your claim within a reasonable time not longer than thirty (30) days after it is received. This time period may be extended for an additional fifteen (15) days for matters beyond the control of the Plan Administrator, including when a claim is incomplete. You will receive written notice of any extension, indicating the reasons for the extension and the date by which a decision is expected to be made. If your claim is incomplete, and the Plan Administrator notifies you of that fact, the time period for deciding your claim will be suspended from the date the notice is provided through the date on which you respond or by which you are supposed to respond. You will be given at least forty-five (45) days in which to respond. The Plan Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your claim.

If the Plan Administrator denies your claim, in whole or in part, you will be furnished with a written notice of adverse benefit determination setting forth:

(1) The specific reason or reasons for the denial;

(2) Reference to the specific Plan provision on which the denial is based;

(3) A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary.

(d) **Appealing a Denial.** If your claim is denied in whole or in part, you may appeal to the Plan Administrator for a review of the denied claim. Your appeal must be made in writing within one hundred eighty (180) days of the Plan Administrator's initial notice of adverse benefit determination or you will lose your right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit In court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

(e) **Decision upon Appeal.** The Plan Administrator will review and decide your appeal within a reasonable time not longer than sixty (60) days after it is submitted and will notify you of its decision in writing. The individual who decides your appeal will not be the same Individual who decided your initial claim denial and will not be that individual's subordinate. The Plan Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. (The identity of a medical expert consulted In connection with your appeal will be provided.) If the decision on appeal affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

(1) The specific reason or reasons for the denial;

(2) The specific Plan provision(s) on which the decision is based;

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

(4) If the Plan Administrator 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

1.18 How are insurance refunds handled?

Any refund provided to the Employer by an insurance company that has issued an insurance contract for a component of the Cafeteria Plan will be allocated as provided herein. The refund will constitute Plan assets only to the extent required by applicable law. The refund will 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 will be (i) used solely for the benefit of the Participants participating in the plan to which the refund relates, and (ii) returned to such Participants in a manner allowed by applicable law (e.g., to provide a refund or 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 will be returned to the Participants no later than three (3) months following the date on which the Employer receives such refund from the insurance company.

1.19 Who has the authority to interpret the Plan?

To the fullest extent permitted under applicable law, the Plan Administrator and any other Plan fiduciary acting in its fiduciary capacity shall have the authority and discretion to interpret and apply Plan terms.

PART II.
GROUP MEDICAL COVERAGE

2.1 How do I enroll and make benefit elections?

An important feature of the Cafeteria Plan is the opportunity it provides you to pay your share of the cost of medical coverage on a pre-tax basis. The medical coverage is provided through your Employer and is referred to herein as the "Group Medical Coverage." Your share of the cost for that coverage is paid with the allocation of Employer Contributions (if any) and pre-tax dollars through salary reduction under this portion of the Cafeteria Plan.

The Group Medical Coverage is described in separate materials which have been provided to you either directly by the carrier (the insurance company or HMO) or by your Employer. Those descriptive materials are incorporated into this summary description by reference and identified in Exhibit B. If you have not been provided this Information, you should contact the Plan Administrator. The benefits under the Group Medical Coverage are provided in accordance with the applicable Group Medical Coverage documents.

The Group Medical Coverage is subject to privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA'').

2.2 How do I become a Participant in this portion of the Cafeteria Plan?

To participate in this portion of the Cafeteria Plan, you must first enroll In the Group Medical Coverage. You may select coverage under the Group Medical Coverage for just yourself, or you may select coverage for yourself and others who are eligible for coverage under the terms of the Group Medical Coverage. Please refer to the contract or policy governing the Group Medical Coverage for information regarding who is eligible for coverage under that plan and how to enroll in that plan.

If you have enrolled in the Group Medical Coverage, then you may participate in this portion of the Cafeteria Plan if you satisfy the general eligibility requirements for the Cafeteria Plan described in section 1.4. If you satisfy those requirements, you must elect to pay your share of the cost of Group Medical Coverage in accordance with Section 1.6.

2.3 How is my cost of Group Medical Coverage paid?

If you participate in this portion of the Cafeteria Plan, your cost of coverage under the Group Medical Coverage is generally paid by allocation of any available Employer Contribution, as indicated in Exhibit B, and to the extent Employer Contribution is insufficient, with pre-tax dollars through salary reduction.

NOTE: You must be a Participant in the Cafeteria Plan for your portion of the premiums to be paid pre-tax.

If you pay the cost of Group Medical Coverage through this portion of the Cafeteria Plan and you have enrolled an individual who is not your spouse or "tax dependent'' (as those terms are defined in Section 1.16), then the taxation of that individual's coverage will be handled as described In Section 1.16.

2.4 What if I am no longer eligible?

If you cease to be eligible for coverage under the Group Medical Coverage, your coverage under that Plan will terminate in accordance with the terms and conditions of that Plan. In most cases, if you lose coverage under the Group Medical Coverage, your participation in this portion of the Cafeteria Plan will cease as well, subject to the change in election rules described in Section 1.8.

If you cease to be eligible to participate in this Cafeteria Plan, your ability to pay for coverage under the Group Medical Coverage on a pre-tax basis through this portion of the Cafeteria Plan stops.

2.5 Can coverage be continued?

If you cease to be eligible for coverage under the Group Medical Coverage, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation coverage is available in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), and applicable continuation requirements under state law. These continuation rights are described later in this summary.

2.6 What if I am subject to a medical child support order?

The Group Medical Coverage recognizes certain medical child support orders that constitute Qualified Medical Child Support Orders ("QMCSOs") under ERISA. If a child is enrolled in the Group Medical Coverage pursuant to a QMCSO, you will be able to pay the cost of that coverage through this portion of the Cafeteria Plan, provided you are eligible to participate as described above. To be a QMCSO certain procedures must be followed. You may obtain a copy of these procedures upon request at no cost.

PART III.
GROUP DENTAL COVERAGE

3.1 How do I enroll and make benefit elections?

An important feature of the Cafeteria Plan is the opportunity it provides you to pay your share of the cost of dental coverage on a pre-tax basis. The dental coverage is provided through your Employer and is referred to herein as the "Group Dental Coverage." Your share of the cost for that coverage is paid with the allocation of Employer Contributions (if any) and pre-tax dollars through salary reduction under this portion of the Cafeteria Plan.

The Group Dental Coverage is described in separate materials which have been provided to you either directly by the carrier (the insurance company or DMO) or by your Employer. Those descriptive materials are incorporated into this summary description by reference and identified in Exhibit B. If you have not been provided this information, you should contact the Plan Administrator. The benefits under the Group Dental Coverage are provided in accordance with the applicable Group Dental Coverage documents.

The Group Dental Coverage is subject to privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA'').

3.2 How do I become a Participant in this portion of the Cafeteria Plan?

To participate in this portion of the Cafeteria Plan, you must first enroll In the Group Dental Coverage. You may select coverage under the Group Dental Coverage for just yourself, or you may select coverage for yourself and others who are eligible for coverage under the terms of the Group Dental Coverage. Please refer to the contract or policy governing the Group Dental Coverage for information regarding who is eligible for coverage under that plan and how to enroll in that plan.

If you have enrolled in the Group Dental Coverage, then you may participate in this portion of the Cafeteria Plan if you satisfy the general eligibility requirements for the Cafeteria Plan described in section 1.4. If you satisfy those requirements, you must elect to pay your share of the cost of Group Dental Coverage in accordance with Section 1.6.

3.3 How is my cost of group dental coverage paid?

If you participate in this portion of the Cafeteria Plan, your cost of coverage under the Group Dental Coverage is generally paid by allocation of any available Employer Contribution, as indicated in Exhibit B, and to the extent Employer Contribution is insufficient, with pre-tax dollars through salary reduction.

NOTE: You must be a Participant in the Cafeteria Plan for your portion of the premiums to be paid pre-tax.

If you pay the cost of Group Dental Coverage through this portion of the Cafeteria Plan and you have enrolled an individual who is not your spouse or "tax dependent'' (as those terms are defined in Section 1.16), then the taxation of that individual's coverage will be handled as described In Section 1.16.

3.4 What happens if I am no longer eligible?

If you cease to be eligible for coverage under the Group Dental Coverage, your coverage under that Plan will terminate in accordance with the terms and conditions of that Plan. In most cases, if you

lose coverage under the Group Dental Coverage, your participation in this portion of the Cafeteria Plan will cease as well, subject to the change in election rules described in Section 1.8.

If you cease to be eligible to participate in this Cafeteria Plan, your ability to pay for coverage under the Group Dental Coverage on a pre-tax basis through this portion of the Cafeteria Plan stops.

3.5 Can coverage be continued?

If you cease to be eligible for coverage under the Group Dental Coverage, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation coverage is available in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), and applicable continuation requirements under state law. These continuation rights are described later in this summary.

3.6 What if I am subject to a medical child support order?

The Group Dental Coverage recognizes certain dental child support orders that constitute Qualified Dental Child Support Orders ("QMCSOs") under ERISA. If a child is enrolled in the Group Dental Coverage pursuant to a QMCSO, you will be able to pay the cost of that coverage through this portion of the Cafeteria Plan, provided you are eligible to participate as described above. To be a QMCSO certain procedures must be followed. You may obtain a copy of these procedures upon request at no cost.

PART IV.
GROUP TERM LIFE AND AD&D BENEFITS

4.1 What benefits are provided?

An important feature of the Cafeteria Plan is the opportunity it provides you to pay your share of the cost of group term life Insurance and/or accidental death and dismemberment insurance coverage on a pre-tax basis (unless otherwise required by the plan to be paid post-tax). The coverage is provided through your Employer and is referred to as the "Group Term Life and AD&D Coverage". Your share of the cost for that coverage is paid with the allocation of Employer Contributions and pre-tax dollars through salary reduction under this portion the Cafeteria Plan.

NOTE: The Plan does not allow the pre-tax payment of the cost of your spouse or dependent's life insurance coverage.

The Group Term Life and AD&D Coverage is fully insured, which means that all benefits are provided through one or more contracts or policies obtained by your Employer with one or more third party insurance carriers. The Group Term Life and AD&D Coverage is described in separate materials which have been provided to you either directly by the insurance carrier or by the Employer. Those descriptive materials are incorporated into this summary description by reference and identified in Exhibit B. If you have not been provided this information, you should contact the Plan Administrator. The group term life and accidental death and dismemberment benefits are provided in accordance with the applicable contract or policy issued by the carrier.

4.2 How do I become a Participant in this portion of the Cafeteria Plan?

To participate in this portion of the Cafeteria Plan, you must first enroll in the Group Term Life and AD&D Coverage. Please refer Exhibit B and to the contract or policy governing the Group Term Life and AD&D Coverage for information regarding how to enroll in that plan.

If you have enrolled in the Group Term Life and AD&D Coverage, then you may participate in this portion of the Cafeteria Plan if you satisfy the general eligibility requirements for the Cafeteria Plan described in Section 1.4. If you satisfy those requirements, you must elect to pay your share of the cost of Group Term Life and AD&D Coverage in accordance with Section 1.6.

4.3 How is my cost of coverage paid?

If you participate in this portion of the Cafeteria Plan, your cost of coverage under the Group Term Life and AD&D Coverage is paid by allocation of any available Employer Contribution, if indicated in Exhibit B, and, to the extent the Employer Contribution is insufficient, with pre-tax dollars (unless otherwise required by the plan to be paid post-tax) through salary reduction. Your Employer will forward the salary reduction dollars (if any) to the insurance carrier along with any Employer Contribution you have designated to be used to pay for this coverage.

NOTE: You must be a Participant in the Cafeteria Plan for your portion of the premiums to be paid pre-tax.

4.4 How much group term life insurance coverage can I purchase?

Up to $50,000 worth of Employer paid coverage may be excluded from your taxable income. For this purpose, "Employer paid" includes coverage automatically provided by the Employer, coverage paid with Employer Contributions, and coverage paid by you on a pre-tax basis through salary reduction under

this Cafeteria Plan. If the face amount of the Employer paid coverage exceeds $50,000, the cost of the coverage in excess of $50,000 will be imputed to you as income to the extent required by law.

4.5 What if I am no longer eligible?

If you cease to be eligible for coverage under the Group Term Life and AD&D Coverage, your coverage under that plan will terminate in accordance with the terms and conditions of that plan. In most cases, if you lose coverage under the Group Term Life and AD&D Coverage, your participation in this portion of the Cafeteria Plan will cease as well, subject to the change in election rules described In Section 1.8.

If you cease to be eligible to participate in this Cafeteria Plan, your ability to pay for coverage under the Group Term Life and AD&D Coverage on a pre-tax basis through this portion of the Cafeteria Plan stops.

4.6 Can coverage be continued?

If you cease to be eligible for coverage under the Group Term Life and AD&D Coverage, you may be able to continue that 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 benefit are provided shall be available to the extent they are not prohibited or preempted by federal law.

PART V.
GROUP VISION BENEFITS

5.1 What benefits are provided?

An important feature of the Cafeteria Plan is the opportunity it provides to pay your share of the cost of vision coverage on a pre-tax basis. The vision coverage is provided through your Employer and is referred to herein as the "Group Vision Coverage." Your share of the cost for that coverage is paid with the allocation of Employer Contributions, if indicated in Exhibit B, and pre-tax dollars through salary reduction under this portion of the Cafeteria Plan.

The Group Vision Coverage is described in separate materials which have been provided to you either directly by the carrier (the insurance company) or by the Employer. Those descriptive materials are incorporated into this summary description by reference and identified in Exhibit B. If you have not been provided this information, you should contact the Plan Administrator. The benefits under the Group Vision Coverage are provided in accordance with the applicable Group Vision Coverage documents.

The Group Vision Coverage is subject to the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

5.2 How do I become a Participant in this portion of the Cafeteria Plan?

To participate in this portion of the Cafeteria Plan, you must first enroll In the Group Vision Coverage. You may select coverage under the Group Vision Coverage for just yourself, or you may select coverage for yourself and others who are eligible for coverage under the terms of the Group Vision Coverage. Please refer to Exhibit B and the contract or policy governing the Group Vision Coverage for information regarding who is eligible for coverage under that plan and how to enroll in that plan.

If you have enrolled in the Group Vision Coverage, then you may participate in this portion of the Cafeteria Plan if you satisfy the general eligibility requirements for the Cafeteria Plan described in section 1.4. If you satisfy those requirements, you must elect to pay your share of the cost of Group Vision Coverage in accordance with Section 1.6.

5.3 How is my cost of group vision coverage paid?

If you participate in this portion of the Cafeteria Plan, your cost of coverage under the Group Vision Coverage is generally paid by allocation of any available Employer Contribution, as indicated in Exhibit B, and to the extent Employer Contribution is insufficient, with pre-tax dollars through salary reduction.

NOTE: You must be a Participant in the Cafeteria Plan for your portion of the premiums to be paid pre-tax.

If you pay the cost of Group Vision Coverage through this portion of the Cafeteria Plan and you have enrolled an individual who is not your spouse or "tax dependent" (as those terms are defined in Section 1.16), then the taxation of that individual's coverage will be handled as described In Section 1.16.

5.4 What if I am no longer eligible?

If you cease to be eligible for coverage under the Group Vision Coverage, your coverage under that Plan will terminate in accordance with the terms and conditions of that Plan. In most cases, if you lose coverage under the Group Vision Coverage, your participation in this portion of the Cafeteria Plan will cease as well, subject to the change in election rules described in Section 1.8.

If you cease to be eligible to participate in this Cafeteria Plan, your ability to pay for coverage under the Group Vision Coverage on a pre-tax basis through this portion of the Cafeteria Plan stops.

5.5 Can coverage be continued?

If you cease to be eligible for coverage under the Group Vision Coverage, you and any others who receive their coverage through you ***may*** be able to continue that coverage. Continuation coverage is available in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), and applicable continuation requirements under state law. These continuation rights are described later in this summary.

5.6 What if I am subject to a medical child support order?

The Group Vision Coverage recognizes certain vision child support orders that constitute Qualified Vision Child Support Orders ("QMCSOs") under ERISA. If a child is enrolled in the Group Vision Coverage pursuant to a QMCSO, you will be able to pay the cost of that coverage through this portion of the Cafeteria Plan, provided you are eligible to participate as described above. To be a QMCSO certain procedures must be followed. You may obtain a copy of these procedures upon request at no cost.

PART VI.
GROUP DISABILITY COVERAGE

6.1 What benefits are provided?

This feature of the Cafeteria Plan describes how you pay your share of the cost of long term disability coverage and/or short term disability coverage. The coverage is provided through your Employer and is referred to herein as the "Group Disability Coverage." Your share of the cost for that coverage is paid through salary reduction under this portion of the Cafeteria Plan.

The Group Disability Coverage is described in separate materials which have been provided to you either directly by the carrier (the insurance carrier) or by the Employer. Those descriptive materials are incorporated into this summary description by reference and identified in Exhibit B. If you have not been provided this information, you should contact the Plan Administrator. The disability benefits are provided in accordance with the applicable contract or policy issued by the carrier.

6.2 How do I become a Participant in this portion of the Cafeteria Plan?

To participate in this portion of the Cafeteria Plan, you must first enroll in the Group Disability Coverage. Please refer to Exhibit B and the contract or policy governing the Group Disability Coverage for information regarding how to enroll in that Plan.

If you have enrolled in the Group Disability Coverage, then you may participate in this portion of the Cafeteria Plan if you satisfy the general eligibility requirements for the Cafeteria Plan described in section 1.4. If you satisfy those requirements, you must elect to pay your share of the cost of Group Disability Coverage in accordance with Section 1.6.

6.3 How is my cost of coverage paid?

If you participate in this portion of the Cafeteria Plan, your cost of coverage under the Group Disability Coverage is paid by allocation of the Employer Contribution available, as indicated in Exhibit A. Any additional cost is your responsibility. The coverage is paid with after-tax dollars. The coverage is paid with pre-tax dollars.

6.4 What are the tax consequences if I receive benefits?

If you receive benefits under the Group Disability Coverage, those benefits will be treated as taxable compensation to you. If you receive benefits under the Group Disability Coverage, those benefits will not be taxable income to you.

6.5 What if I am no longer eligible?

If you cease to be eligible for coverage under the Group Disability Coverage, your coverage under that Plan will terminate in accordance with the terms and conditions of that Plan. In most cases, if you lose coverage under the Group Disability Coverage, your participation in this portion of the Cafeteria Plan will cease as well, subject to the change in election rules described in Section 1.8.

If you cease to be eligible to participate in this Cafeteria Plan, your ability to pay for coverage under the Group Disability Coverage through this portion of the Cafeteria Plan stops.

PART VII.
HSA CONTRIBUTION FEATURE

7.1 What benefits are provided?

The Cafeteria Plan permits you to elect to make contributions to a health savings account ("HSA") under the HSA Contribution Feature. Under the HSA Contribution Feature, you provide a source of pre-tax dollars by entering into a salary reduction arrangement with your Employer. You may also use any available Employer Contributions. Those pre-tax dollars and the Employer Contribution, if any, will be contributed to your HSA. You save Social Security and income taxes on the amount of your salary reduction for HSA contributions.

Your Employer may also make contributions to your HSA. If so, your Employer will provide additional information about the amount and timing of those contributions.

7.2 Am I eligible and how do I become a Participant?

To become a Participant in the HSA Contribution Feature, you must first become a Participant in the Cafeteria Plan. You must also satisfy the eligibility requirements for the HSA Contribution Feature. The HSA Contribution Feature's eligibility requirements are, in general, the same as the eligibility requirements for the Cafeteria Plan as described in Section 1.4. In addition, you must meet certain other requirements in order to participate in the HSA Contribution Feature. To be eligible, you must:

(a) be covered by the Employer's qualifying high deductible health plan; and

(b) not have any health coverage through the Employer other than coverage under the Employer's qualifying high deductible health plan, "Permitted Insurance," and/or "Permitted Coverage";

If you satisfy those requirements, you become a Participant in the HSA Contribution Feature by electing benefits under the HSA Contribution Feature during your initial or subsequent annual enrollment periods.

Caution: The fact that you are eligible to participate in the HSA Contribution Feature does not necessarily mean you are eligible to contribute to an HSA. Other requirements apply. You are responsible for determining whether you have satisfied those other requirements. Please contact your personal tax advisor for additional information.

7.3 What is a Qualifying High Deductible Health Plan?

A "Qualifying High Deductible Health Plan" generally is a health plan providing coverage that meets one of the following requirements:

(a) self-only coverage with a deductible of at least $1,350 (as indexed for inflation) before any reimbursement is made for eligible medical expenses (other than preventive care) and with an annual out-of-pocket limit of not more than $6,650 (as indexed for inflation); or

(b) family coverage with a deductible of at least $2,700 (as indexed for inflation) before any reimbursement is made for eligible medical expenses (other than preventive care), without an embedded individual deductible less than $2,700, and with an annual out-of-pocket limit of not more than $13,300 (as indexed for inflation).

NOTE: A health plan that covers non-preventive care related prescription drugs prior to the specified deductible is not a Qualifying High Deductible Health Plan.

7.4 What is Permitted Insurance and Permitted Coverage?

"Permitted Insurance" is:

(a) 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;

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

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

"Permitted Coverage" is coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. Permitted coverage includes some medical reimbursement accounts and health reimbursement arrangements (HRAs), such as limited scope medical reimbursement accounts and HRAs (i.e., the Limited Scope Health FSA provided through this Cafeteria Plan), HRAs for which the payment or reimbursement of medical expenses (except expenses for preventive care, dental care, vision care, or long-term care premiums) is suspended, post-deductible medical reimbursement accounts and HRAs, and retirement HRAs. It also includes wellness programs and employee assistance programs that do not provide significant benefits in the nature of non-preventive medical care or treatment.

7.5 What is my HSA?

Your HSA is a health savings account (as defined under the Internal Revenue Code) established by you with a third party trustee/custodian (e.g., bank or insurance company) that is authorized to be the trustee of HSAs. Your Employer does not establish or sponsor your HSA. Furthermore, your Employer does not own your HSA; it is owned by you. [However, for administrative convenience, your Employer has chosen the trustee/custodian to which it will forward contributions.]

You may invest the funds in your HSA as allowed by the trustee/custodian of the account. Your Employer has no control of or responsibility for the investment of your HSA.

7.6 What are the limits on the amount of contributions?

The maximum contributions you may make through this HSA Contribution Feature shall be determined in accordance with the following rules:

(a) Impact of Employer Contributions. The applicable limit on contributions, as determined in accordance with the following rules, shall be reduced by the amount of contributions made by the Employer to your HSA.

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

(c) Catch Up Contributions. An additional "catch-up" amount (determined on a monthly basis) can be contributed if you attain age 55 before the close of the taxable year.

(d) Pro-rated Limit if Not Eligible on December 1st. If you cease to satisfy the eligibility requirements described above prior to December 1st of any calendar year, your contribution limit for that year shall be determined by multiplying 1/12 of the applicable limit describe in paragraphs (a) and (b) by the number of months for which you satisfied the eligibility requirements described above (as of the first day of the month).

Note: Your Employer is not required to take any corrective action in the event the amount of your HSA contributions made prior to the date on which you cease to satisfy the eligibility requirements described above exceed this pro-rated limit.

(e) Special Rule if Eligible on December 1st. If you become eligible to make contributions under this HSA Contribution Feature (as provided above) during the taxable year and you are eligible on December 1st of such year, you are 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: If you become eligible to make HSA contributions on July 1st and you remain eligible through December 1st, you may begin making contributions to your 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.

Caution: The fact that you are participating in the HSA Contribution Feature does not necessarily mean you are eligible to contribute to an HSA. Other requirements apply. If you are ineligible for HSA contributions for reasons unknown to your Employer, your contributions under this HSA Contribution Feature may exceed the amount of contributions you are allowed to make to an HSA. You are responsible for determining whether you are eligible for HSA contributions and the limit on your contributions for any given year. Please contact your personal tax advisor for additional information.

7.7 What happens if my contributions exceed the contribution limit?

If the contributions to your HSA exceed the applicable maximum contribution limit for a year, the excess contributions typically will be included in your income and an excise tax will be imposed upon them. You will also be taxed on any earnings earned on the excess amounts. However, you can avoid the excess tax if you take a distribution of the excess contributions (and the net income attributable to the excess contribution) before the last day (including extensions) for filing your federal income tax return.

7.8 What are the tax consequences of the HSA Contribution Feature?

The contributions made under this HSA Contribution Feature will not be included in your gross income, unless they exceed the applicable maximum contribution limit as discussed above.

7.9 What are the rules regarding distributions from my HSA?

Your Employer has no control over or involvement with distributions made from your HSA. Your Employer does not substantiate expenses for which such distributions are made. Information regarding the procedure for obtaining distributions and the consequences of taking distributions is available from the trustee/custodian of your HSA.

7.10 When does my participation end?

Participation in the HSA Contribution Feature ends upon the earlier of the date your participation in the Cafeteria Plan ceases or the date you no longer satisfy the eligibility requirements described above. However, you need not be a participant in the HSA Contribution Feature (or be employed by the Employer) in order to obtain distributions from your HSA. In addition, you may make contributions to your HSA outside this Cafeteria Plan, provided you are eligible to do so under IRS rules, after you have left employment with the Employer or have ceased to be a participant in the Cafeteria Plan.

NOTE: This HSA Contribution Feature is not a group health plan for purposes of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), 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. However, COBRA, FMLA, and USERRA may apply to the Qualifying High Deductible Health Plan.

7.11 Can the contributions made to my HSA be forfeited?

No, once the contributions have been deposited in your HSA, you will have a nonforfeitable interest in the funds. You will be free to request a distribution of the funds or to move them to another provider of HSAs, to the extent allowed by law.

7.12 What are the reporting requirements?

Your Employer is responsible for reporting contributions made to your HSA through this HSA Contribution Feature on your Form W-2. You are also responsible for reporting contributions to your HSA, and for reporting distributions from your HSA, on appropriate forms available from the IRS.

7.13 Is the HSA Contribution Feature governed by ERISA?

This HSA Contribution Feature and your HSA are not subject to ERISA. The ERISA Rights section of this SPD does not apply to the HSA Contribution Feature or your HSA.

PART VIII.
CONTINUATION COVERAGE

8.1 What are my continuation rights under COBRA?

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires most employers with twenty (20) or more Employees to offer Employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may have to pay all of the premium for the continuation coverage. The Group Medical Coverage, Group Dental Coverage, Group Vision Coverage, shall be operated consistent with COBRA. Please refer to the Employer's COBRA policies and procedures contained in a separate document and is incorporated by reference into this summary. This document is available to you upon request, at no charge.

8.2 What are my continuation rights under USERRA?

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

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

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

8.4 What are my continuation and/or conversion rights for group term life insurance coverage under state law?

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

PART IX.
FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act of 1993 ("FMLA") imposes certain obligations on employers with fifty (50) or more Employees. This Cafeteria Plan shall be administered in a manner consistent with the FMLA and the Employer's FMLA Policy required thereunder. You will be provided with a complete explanation of FMLA rights and responsibilities. In the event you are entitled and elect to continue coverage under the Plan during an FMLA leave, such coverage shall terminate if your FMLA leave expires and you do not return to work.

NOTE: You should contact your Employer regarding any FMLA questions.

PART X.
STATEMENT OF ERISA RIGHTS

As a Participant in certain Component Benefits of this Cafeteria Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

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

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

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

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

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

COBRA Rights.

ERISA also provides that all Participants shall be entitled to continue health coverage for yourself, your spouse or your dependents if there is a loss in coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries.

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

Enforce Your Rights.

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

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

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

Very Important: Exhaustion of Administrative Procedures Required. The right to maintain a court action is subject to the plan's requirements that administrative procedures be completed first. This is called exhaustion of administrative remedies. Failure to exhaust administrative procedures may preclude you from bringing an action in court.

Assistance with Your Questions.

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

EXHIBIT A:
EMPLOYER AND PLAN INFORMATION

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