Texas Operators Association, Inc.

Texas Operators Association Welfare Benefit Plan

Summary Plan Description

Effective January 1, 2021

This document, together with the certificates of coverage, benefits booklets, and schedules of benefits for the benefit programs listed in Appendix B, constitutes the Summary Plan Description required by ERISA § 102.

TABLE OF CONTENTS

Este documento contiene un resumen en inglés de sus derechos y beneficios bajo el Plan de salud grupal de su empleador. Si tiene dificultades en comprender cualquier parte de este documento, por favor comuníquese con el Administrador de reclamos al: 833-511-8962.

1. Definitions

Capitalized terms used in the Plan have the following meanings:

ACA "ACA" means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, and as subsequently amended.

Association "Association" means the Texas Operators Association, a Texas nonprofit corporation and a Texas health group cooperative organized under Texas Insurance Code Chapter 1501.

COBRA "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code "Code" means the Internal Revenue Code of 1986, as amended.

Employee "Employee" means a person who: (a) receives remuneration for performing services for a Participating Employer in the conduct of the Participating Employer's regular business and who is classified by the Participating Employer, pursuant to its regular administrative practices, as a common law employee; or (b) has an ownership interest in a Participating Employer and performs personal services for the Employer for which the person receives wages or income.

Employer "Employer" means a member of the Association in good standing as defined by the Association's Bylaws, and an employer of one or more non-spouse employees determined to be eligible to participate in the Plan.

ERISA "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

HIPAA "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

Insurance Company "Insurance Company" means an insurance company that is qualified to do business in Texas and that issues a group insurance contract or policy to the Association to provide certain benefits under the Plan to Employees and their spouses and dependents.

Participating Employer "Participating Employer" means an Employer that has elected to make some or all benefit options under the Plan available for the Participating Employer's Employees, executed an Employer Participation Agreement, and has been designated as a Participating Employer by the Plan Administrator.

Plan "Plan" means the Texas Operators Association Welfare Benefit Plan.

Plan Administrator "Plan Administrator" means the Association or its designee.

Plan Sponsor "Plan Sponsor" means the Association.

2. Introduction

The Association maintains the Plan for the exclusive benefit of the Participating Employers' employees and their spouses and dependents. The Plan provides benefits through a number of component benefit programs. It is important to note that Participating Employers may choose to offer some or all of the Benefit options listed on the Benefit Option Appendix. Therefore, please consult with your Employer or the Plan Administrator for questions regarding the specific benefit options that are available to you.

Each of the component benefit programs is summarized in an insurance policy, certificate of insurance, or benefits booklet issued by an Insurance Company. A copy of each policy, certificate, or booklet is attached to your benefit option Appendix

Some of these component benefit programs may require you to make an annual election to enroll for coverage. The details of such annual elections are described in the attachments to the Benefit Option Appendix.

This document and its Appendices, including attachments, constitute the Summary Plan Description (SPD) for the Plan as required by ERISA § 102.

3. General Information About the Plan

Plan Name

Texas Operators Association Welfare Benefit Plan.

Type of Plan

Welfare plan providing medical coverage, dental coverage, vision coverage.

Plan Year

The plan year is January 1 through December 31.

Plan Number

The plan number is 501.

Effective Date

The effective date of the plan is January 1, 2021.

Funding Medium and Type of Plan Administration

All benefits under the Plan are fully insured. Please see your Benefit Option Appendix for the Insurance Company that insures each component benefit program. The Insurance Companies, not the Association or your Employer, are responsible for processing and paying claims. The Association shares responsibility with the Insurance Companies for administering these program benefits, as described in Section 7.

All premiums associated with the fully-insured programs will be paid by the Participating Employers, and a portion of the premiums may be reimbursed to the Participating Employers through Employee contributions as determined by the Participating Employer. Employees' contributions (if any) may be made through pre-tax payroll reductions where permitted. The Association will work with the Plan Administrator and the Participating Employer to provide a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request for each of the component benefit programs, as applicable.

Plan Sponsor

Texas Operators Association, Inc.
8955 Katy Freeway, Suite 310
Houston, Texas 77024

	737-236-5149
Plan Sponsor's Employer Identification Number	85-1623063
Contact Information For Claims Administrators	Please see your Benefit Option Appendix for information regarding the contact information for the Claims Administrators.
Plan Administrator	Texas Operators Association, Inc. 8955 Katy Freeway, Suite 310 Houston, Texas 77024 737-236-5149
COBRA Administrator	Benefitexpress P.O. Box 2798 Omaha, NE 68103 833-511-8962
Named Fiduciary	Texas Operators Association, Inc. 8955 Katy Freeway, Suite 310 Houston, Texas 77024
Agent for Service of Legal Process	J.M. Trippon & Company, P.C. 8955 Katy Freeway, Suite 310 Houston, Texas 77024
Important Disclaimer	Benefits under the Plan are provided pursuant to insurance contracts. If the terms of this document conflict with the terms of such insurance contract, then the terms of the insurance contract will control rather than this document. In addition, to the extent this SPD is inconsistent with the terms of the Plan Document, the Plan Document will control.

4. Eligibility and Participation Requirements

Eligibility and Participation

To be eligible to participate in the Plan, a person must be an Employee who works, on average, at least 30 hours per week. The following persons are excluded from participation in the Plan and any component benefit program:

(a) Any Employee who, on average, works less than 30 hours per week.

(b) Any Employee classified by a Participating Employer, pursuant to its regular administrative practices, as a seasonal or leased employee, regardless of whether such classification is in error, is not eligible to participate (and is therefore not an eligible Employee) in the Plan.

(c) Any person classified by a Participating Employer, pursuant to its regular administrative practices, as an independent contractor, regardless of whether such classification is in error.

(d) Any Employee whose terms and conditions of employment are covered under a collective bargaining agreement unless the terms of such

collective bargaining agreement specifically provide for participation in the Plan.

A dependent (for example, a spouse, domestic partner, or child) of an Employee is eligible to participate in the Plan when an Employee becomes eligible to participate in the Plan and the dependent satisfies the requirements for dependent coverage set forth in the applicable insurance contract. At any time, the Plan may require proof that a person qualifies or continues to qualify as a dependent as defined by the Plan and the insurance contract.

To determine whether you or your family members are eligible to participate in a component benefit program, please read the eligibility information for the applicable component benefit programs, which can be found in the attachments to your Benefit Option Appendix. Please note that some Participating Employers may not elect to offer all benefit options the Association makes available through the Plan.

Certain component benefit programs may require that you make an annual election to enroll for coverage. Information about enrollment procedures is found in the attachments to your Benefit Option Appendix. If you are an eligible Employee, you may begin participating in the Plan upon your election to participate in a component benefit program in accordance with the terms and conditions established for that program.

5. Enrollment

Initial Enrollment

Employees who are or become eligible for coverage must enroll himself, herself, and any dependents by submitting an application form, along with required supporting documentation, within 30 days after the date of becoming eligible.

Open Enrollment

Prior to the start of a Plan Year, the Plan will have an open enrollment period. This is the period during which (a) eligible Employees who are not covered under this Plan may elect to begin coverage effective the first day of the upcoming Plan Year, and (b) participating Employees will be given an opportunity to change their coverage effective the first day of the upcoming Plan Year.

Special Enrollment Periods

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the other employer stops contributing toward your or your dependents' other coverage). In this situation, certain events will trigger a special enrollment period, which means an eligible Employee may enroll in coverage under the Plan. Please see the applicable certificate of coverage or benefits booklet for more details about special enrollment events.

6. Termination and Continuation of Coverage

Termination of Participation and Coverage

Your participation and the participation of your eligible family members in the Plan and, as applicable, the medical, dental, and vision benefit programs will terminate on the last day of the month in which you terminate employment with the Participating Employer. If the terms of this document conflict with the terms of the applicable insurance contract or governing plan document, then the terms

of the insurance contract or governing plan document will control rather than this document unless otherwise required by law.

Coverage also may terminate if you fail to pay your share of an applicable premium, if your hours drop below any required threshold, if you elect to discontinue coverage, if you submit false claims, if you were originally improperly enrolled in the plan (which will be treated as fraud or as an intentional misrepresentation for purposes of permitting a rescission of coverage), or for any other reason as set forth in the attachments to this SPD or other governing documents for the component benefit program. Retroactive rescission of coverage is permitted in certain limited circumstances; however, the Plan and all component benefit programs will comply with all applicable ACA requirements concerning when and under what circumstances a rescission of group health plan coverage is permissible. You should consult the applicable certificate of insurance or benefits booklet for specific termination events and information.

Continuation Coverage Under COBRA

If medical, dental, or vision coverage for you or your eligible family members ceases because of certain "qualifying events" specified in COBRA (such as termination of employment, reduction in hours, divorce, death, or a child ceasing to meet the definition of dependent), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time. If you have questions about your COBRA rights, please read the "Summary of Rights and Obligations Regarding Continuation of Plan Coverage" below.

Summary of Rights and Obligations Regarding Continuation of Plan Coverage

This notice is intended to inform you, in summary fashion, of your rights and obligations under COBRA. It does not fully describe your continuation coverage rights. For additional information about your rights and obligations regarding continuation coverage, you should contact the COBRA Administrator. Nothing in this SPD is intended to provide any greater rights than those required by applicable law.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Texas has enacted a Texas COBRA law that requires small employers to provide rights similar the federal COBRA law.

COBRA continuation coverage can become available to you when you would otherwise lose your health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their health coverage. A person who continues coverage is required to pay the entire premium for the continuation coverage.

***Important Note*:** At the time this SPD was prepared, the United States was in a national state of emergency due to the COVID-19 pandemic. Due to the pandemic, federal regulatory agencies temporarily suspended certain deadlines relating to health plans during the "Outbreak Period," which is the time period from March 1, 2020 until 60 days after the earlier of: (i) the date the national emergency due to the COVID-19 pandemic declared by the President ends; or (ii) the date the COVID-19 outbreak for the applicable part of the United States ends. This temporary suspension applies to the deadlines described below for you or your dependents to give notice of a qualifying event, second qualifying event or

disability, elect COBRA continuation coverage, and pay any COBRA premiums. Please ask the COBRA Administrator if you need more information.

You May Have Other Options Available to You When You Lose Group Health Coverage.

If you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of health coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under one of the benefit options that is considered a "group health plan" is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under a health plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under a health plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under a health plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;

- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan's COBRA Administrator within 60 days after the qualifying event occurs (within 30 days of loss of Social Security disability status). An untimely Qualifying Event Notice is considered to have no effect and shall be rejected.

The Plan requires that you provide the Qualifying Event Notice in writing by mail to the Plan Administrator for COBRA administration. Under no circumstances will an oral notice be effective.

In the Qualifying Event Notice, you are required to provide certain information regarding the qualifying event such as an identification of the type of event, the date the event occurred and the name of the individual to whom the event is applicable. The qualifying events listed below require specific documentation submitted with the Qualifying Event Notice:

Qualifying Event	**Documentation Required with Notice**
Divorce or legal separation	Certified copy of the court order granting the divorce or legal separation
Death of covered employee	Copy of death certificate
Qualification for Social Security Disability	Copy of the Social Security Administration determination
Loss of Social Security Disability Status	Copy of Social Security Administration final determination

To be considered valid, the notice must be completed in full and all required enclosures must be supplied. However, the Plan provides that a Qualifying Event Notice otherwise received timely, but which does not contain all required information or enclosures will not be considered untimely if the COBRA Administrator is able to identify the Plan, identify the covered employee or qualified beneficiary, identify the qualifying event or disability, and identify the

date on which the qualifying event occurred. The COBRA Administrator, in such event, may require additional supplementary information from the covered employee or qualified beneficiary. The completed Qualifying Event Notice must be mailed to the COBRA Administrator at the address listed in this SPD. It is recommended that you send the completed Qualifying Event Notice by registered mail, return receipt requested, but it is not required. When you submit a completed Qualifying Event Notice, you need to retain a copy (including copies of all enclosures) and any proof of mailing.

Second-Chance COBRA Election

If you are an employee eligible to receive Trade Adjustment Assistance (TAA) benefits, and you (i) lost health coverage due to a job loss that resulted in eligibility for TAA benefits, and (ii) failed to elect COBRA during your original COBRA election period, you may be entitled to a second 60-day COBRA election period. The new election period begins on the first day of the month in which you are certified for TAA benefits, but your election must be made within six months of the initial loss of group health coverage. In addition, the petition for trade assistance benefit certification must not have been filed before November 4, 2002.

You may make an election under the second 60-day election period by completing the COBRA Election Notice which you can request by contacting the COBRA Administrator and returning it to the COBRA Administrator at the indicated address, within the 60-day period and before expiration of the six month eligibility period. If you elect COBRA under this "second-chance" provision, your maximum period of continuation coverage will be based on the date of your original qualifying event. Your coverage will begin on the first day of the 60-day "second-chance" election period. In addition, the period between your original loss of coverage and the beginning of the 60-day second chance election period will not count against the 63-day HIPAA break in coverage rule for purposes of pre-existing conditions. The COBRA Election Notice will provide you with additional information regarding electing COBRA during this second-chance period.

How Is COBRA Continuation Coverage Provided?

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To notify the COBRA Administrator of the determination by the Social Security Administration that you, your spouse or your dependent is eligible for disability, a Qualifying Event Notice must be completed and returned to the COBRA Administrator. A copy of the determination by the Social Security Administration must be submitted with the Qualifying Event Notice.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information on the Health Insurance Marketplace, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area, please visit www.healthcare.gov.

Continuation Coverage Under USERRA

In addition to COBRA rights, you, your spouse, and covered dependents may be entitled to continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you lose your eligibility under the Plan because you fail to worked the required number of hours for more than 31 days because of duty in any of the following uniformed services:

- the Armed Forces (Army, Navy, Air Force, Marines);
- the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty;
- the commissioned corps of the Public Health Service;
- other categories of personnel designated by the President of the United States in time of war or emergency.

This extended coverage will last no more than 24 months and cannot be extended regardless of the occurrence of any subsequent event. All rights guaranteed by USERRA are dependent on Uniformed Service that ends honorably. In general, the rights guaranteed by USERRA do not apply if the aggregate length of your service exceeds five years. If you elect coverage, you will be responsible for paying the appropriate premium amounts.

For additional information about your rights and obligations, please contact the Claims Administrator for the applicable benefit program.

7. Summary of Plan Benefits

Benefits and Contributions

The Plan provides medical, dental, vision benefit programs. Participating Employers may not offer all of the benefits that the Association makes available through the Plan. Please ask your Participating Employer for information regarding the specific benefit options available to you and your eligible family members. A summary of each benefit provided under the Plan is set forth in the attachments to the Benefit Option Appendix.

The premiums for the benefits provided through the component benefit programs will be paid by Participating Employer contributions and/or Employee contributions. Some of the premiums may be paid in part by Employer contributions and in part by Employee contributions and some may be paid wholly by Employee contributions or wholly by Employer contribuions. The Participating Employer will determine and periodically communicate your share of the cost of the premiums for the benefits you elect, and it may change that determination at any time.

The Participating Employer will prepay in advance each month the premium amounts for its participating Employees. The Participating Employer will then obtain reimbursement from its participating Employees for their portion of the premium amounts for their elected coverage(s). This generally will be done through payroll reductions unless an Employee is on unpaid leave or terminates

employment in which event you are responsible for working out a reimbursement plan with your Participating Employer.

Plan Administration

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan.

With respect to the fully insured component benefits offered under the Plan, the Plan Administrator has contractually delegated certain fiduciary and administrative duties under the Plan to the Insurance Companies. For all component benefits offered under the Plan, the Plan Sponsor has contractually delegated the discretionary authority to interpret the Plan in order to make benefit determinations as it may determine in its sole discretion to the Claims Administrators. The Plan Administrator retains the discretionary authority to make factual determinations as to whether any individual is entitled to eligible to participate in the Plan.

Insurance Companies

All benefits under the Plan are fully insured through group insurance contracts. Group insurance contracts with Insurance Companies provide for the following benefits: medical; dental; and vision. Please see your Benefit Option Appendix for information concerning which Insurance Company is responsible for each benefit option.

The Insurance Companies are responsible for: (a) determining eligibility for and the amount of any benefits payable under their respective component benefit plans; and (b) prescribing claims and appeal procedures to be followed and the claims forms to be used by employees pursuant to their respective component benefit plans.

Questions

If you have any general questions regarding the Plan, please contact:

Texas Operators Association, Inc.
8955 Katy Freeway, Suite 310
Houston, Texas 77024
info@txoa.org

If you have any question regarding your eligibility for, or the amount of, any benefit payable under the component benefit plans, please contact the appropriate Insurance Company.

8. Circumstances That May Affect Benefits

Denial, Recovery, or Loss of Benefits

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates. See Section 6.

Your benefits will also cease upon termination of the Plan.

Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. For example, benefits may

be denied under the dental benefit programs if you have a preexisting condition and incur costs within the exclusionary period. If the Plan pays for health care services to treat an injury or illness caused by a third party, then the Plan and the applicable Insurance Company have the right to seek repayment from the third party, any insurance company that insures the third party, or from any judgment, settlement, award, or payments that you may receive as a result of the accident or event that caused the injury or illness.

You should consult the certificates of insurance, benefits booklets, and other governing documents for additional information.

9. Qualified Medical Child Support Orders

Qualified Medical Child Support Orders

With respect to component benefit plans that are group health plans, the Plan will also provide benefits as required by any qualified medical child support order (QMCSO) (defined in ERISA § 609(a)). A "medical child support order" (MCSO) is an order, decree, or judgment of a court of competent jurisdiction that: (i) is made pursuant to a state domestic relations law (including a community property law) and provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to the child under the group health plan; or (ii) enforces a law relating to medical child support described in Social Security Act § 1908 which respect to a group health plan.

A QMCSO is a medical child support order that (i) creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan, (ii) provides certain required information with respect to the order, and (iii) does not require the Plan to provide benefits not otherwise available under the Plan, except to the extent necessary to meet the requirements of Social Security Act § 1908.

To be a QMCSO, the order must clearly state:

(a) the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order (however, the name and mailing address of the state or political subdivision thereof may be substituted);

(b) a reasonable description of the type of coverage to be provided by the Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined;

(c) the period to which such order applies; and

(d) each plan to which such order applies.

The Plan Administrator must promptly notify the participant and each alternate recipient of the receipt of a medical child support order and the Plan's procedures for determining whether medical child support orders are QMCSOs. Within a reasonable period after receipt of the order the Plan Administrator must determine whether the order is a QMCSO and notify the participant and each alternate recipient of the determination. Each component plan that is a group health plan

must establish reasonable procedures to determine whether medical child support orders are QMCSOs. Such a procedure must be in writing, provide notification to each person specified in a MCSO as eligible to receive plan benefits, and permit an alternate recipient to designate a representative for receipt of copies of notices with respect to the MCSO.

10. Statement of ERISA Rights

Your Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Plan Sponsor is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan 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 Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan 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 that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Sponsor to provide the materials and pay you up to $110 (adjusted for inflation) per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored in whole or in part, and if and only if you have exhausted the claims procedures available to you under the Plan (discussed in Section 14), 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 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 if, for example, it finds your claim is frivolous.

To the fullest extent permitted under applicable law, your 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 if you need assistance in obtaining documents from the Plan Sponsor or 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 contact 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 at 1-866-444-3272.

11. Additional Legal Rights

Special Rights on Childbirth

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

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides health plan participants with a number of rights including, but not limited to, prohibiting group health plans from discriminating with regard to eligibility, premiums, or contributions based on any health status-related factor or preexisting condition. The Plan complies with all applicable requirements of HIPAA.

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Plan's medical coverages provide benefits for mastectomy and post-mastectomy reconstruction. Coverage for post-mastectomy reconstructive surgery includes: all stages of reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction on the other breast to produce a

symmetrical appearance; and prostheses and treatment of physical complications during all stages of mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to the other medical and surgical benefits provided under this Plan. Please see the applicable Schedule of Benefits and certificate of coverage or benefits booklet for more information about deductibles and coinsurance.

Michelle's Law

Michelle's Law applies to component plans that are group health plans for plan years beginning on or after October 9, 2009 (for calendar year plans, the law is effective beginning January 1, 2010). Michelle's Law provides continued coverage under group health plans for dependent children who are covered under the Employer's group medical plan, as a student but lose their student status because they take a medically necessary leave of absence from school.

As a result, if your child is no longer a student, as defined in the plan, because he/she is on a medically necessary leave of absence, your child may continue to be covered under the Plan for up to one year from the beginning of the leave of absence. This continue coverage applies if, immediately before the first day of the leave of absence, your child was (a) covered under the plan and (b) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at that institution, that:

(a) begins while the child is suffering from a serious illness or injury;

(b) is medically necessary; and

(c) causes the child to lose student status for purposes of coverage under the plan.

This coverage provided to dependent children during any period of continued coverage:

(a) is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the plan would otherwise terminate; and

(b) stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the plan is changed during this one-year period, the plan must provide the changed coverage for the dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the plan no longer provides coverage for dependent children.

If you believe your child is eligible for this continued coverage, the child's treating physician must provide a written certification to the plan stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

Mental Health Parity Act

The Mental Health Parity Act (MHPA) of 1996 applies to any component plans that are group health plans. MHPA was originally enacted to provide parity between mental health benefits and medical/surgical benefits. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) added provisions related to substance use disorder benefits and requires parity in financial requirements and treatment limitations, and became effective for plan years beginning after October 3, 2009 (for calendar year plans, on January 1, 2010).

Nothing in the MHPA or MHPAEA requires a component group health plan to offer mental health benefits or substance use disorder benefits. However, if the particular component plan does elect to provide such coverage, then the parity requirements will apply, in accordance with current regulations.

If you have questions about the MHPA or the MHPAEA, please contact the applicable Insurance Company, or visit the DOL website at https://www.dol.gov/general/topic/health-plans/mental.

Genetic Information Nondiscrimination Act of 2008 (GINA)

In accordance with Title I of the Genetic Information Nondiscrimination Act of 2008, in no event shall the Plan or any of its insurers discriminate against any Participant on the basis of genetic information with respect to eligibility, premiums or contributions.

ACA

Any component plans that are group health plans will comply with the latest guidance and IRS, DOL, and HHS regulations interpreting ACA. This Plan is not a "grandfathered health plan" under the ACA. Questions regarding the Plan's status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272, or visit www.dol.gov/ebsa/healthreform

FMLA Leave

If the Family and Medical Leave Act of 1993 (FMLA) applies to your Employer and you take family or medical leave under the FMLA, then you have the option to continue health coverage during your absence or suspend coverage while you are on FMLA leave. If you choose to continue health coverage during your absence, you are responsible for the appropriate monthly contribution for coverage during your leave. The coverage will continue as if you were actively working until the earlier of the expiration date of your FMLA leave or the date you give notice to Employer that you will not return to work from your leave. For additional information about coverage during FMLA leave, please contact the applicable Claims Administrator for the benefit program.

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

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

If you or your dependents are already enrolled in Medicaid or CHIP, contact the Texas State Medicaid office to find out if premium assistance is available:

Website: http://gethipptexas.com/

Phone: 1-800-440-0493

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

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

12. Amendment or Termination of the Plan

Amendment or Termination

The Association, as Plan Sponsor, acting through its applicable governing body, has the right to amend or terminate the Plan at any time within its discretion. The Plan may be amended or terminated by a written instrument adopted by the Association or any of its duly-authorized delegates.

13. No Contract of Employment

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Association or between you and any Employer to the effect that you will be employed for any specific period of time.

14. Claims Procedures

Claims for Fully Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits of the component benefit programs provided under insurance contracts, the respective Insurance Company is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the Insurance Company of a component benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign, and submit a written claim on the insurer's form. In that case, the form is available from the Plan Administrator.

The Insurance Company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA and applicable federal health care reform law and regulations. The Insurance Company is obligated to comply with these legal requirements with respect to claims and appeals procedures. The Insurance Company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the Insurance Company denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Insurance Company for a review of the denied claim. The Insurance Company will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and other applicable laws. If you don't appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court).

See the attached certificate of insurance or benefits booklet for more information about how to file a claim and for details regarding the Insurance Company's claims procedures, including with respect to internal or external appeals, to the extent required by federal health care reform legislation.

***Important Note*:** At the time this SPD was prepared, the United States was in a national state of emergency due to the COVID-19 pandemic. Due to the pandemic, federal regulatory agencies temporarily suspended certain deadlines relating to health plans during the "Outbreak Period," which is the time period from March 1, 2020 until 60 days after the earlier of: (i) the date the national emergency due to the COVID-19 pandemic declared by the President ends; or (ii) the date the COVID-19 outbreak for the applicable part of the United States ends. If you have questions about the time periods applicable to your claim or appeal in light of this suspension of deadlines, please ask the applicable Insurance Company.

* * *

PARTICIPATING EMPLOYER APPENDIX

Participating Companies	Effective Date of Participation
261, Inc.	January 1, 2021
210 Hospitality, Inc.	January 1, 2021
22One, LLC	January 1, 2021
2MCBL, Inc	January 1, 2021
2RM Enterprises	January 1, 2021
356 Inc	January 1, 2021
3J&Donna, Inc.	January 1, 2021
4610 Restaurant Groups, Inc.	January 1, 2021
51705 Strong, Inc	January 1, 2021
7 Nguyens, LLC	January 1, 2021
967169, Inc.	January 1, 2021
A Clear Purpose, Inc.	January 1, 2021
A7 Restaurant Group, Inc	January 1, 2021
Aaron Grant	January 1, 2021
ACCIO Chicken	January 1, 2021
Acosta Ventures	January 1, 2021
ActAsOne, Inc.	January 1, 2021
ADC4EVER,INC	January 1, 2021
ADLTP, Inc	January 1, 2021
Adpareo, Inc	January 1, 2021
Adventure Awaits Inc.	January 1, 2021
AFTEX Prov, Inc.	January 1, 2021
Agnew Restaurant Services LLC	January 1, 2021
AHTM, INC	January 1, 2021
AJMartinez, LLC	January 1, 2021
Albrecht Restaurants LLC	January 1, 2021
Asher Collins	January 1, 2021
Ashford Unlimited Inc	January 1, 2021
Astuto Jamon Inc	January 1, 2021
Aviles Restaurant Group	January 1, 2021
B.T. Henckel, Inc.	January 1, 2021
B-6 Services Inc	January 1, 2021
Baca ERA, Inc.	January 1, 2021
Baca Restaurant Group, Inc.	January 1, 2021
BAWE, Inc.	January 1, 2021
Bear Legacy Inc.	January 1, 2021
Beebs Restaurant Group, Inc.	January 1, 2021
BHenckel, Inc	January 1, 2021
BKEP Group Inc	January 1, 2021
BML Brands, Inc	January 1, 2021
Bow Tie Kellys Inc	January 1, 2021
Breedlove Resources LLC	January 1, 2021
Bridges to Serve, LLC.	January 1, 2021

BTK Restaurant Group	January 1, 2021
Buentello Inc	January 1, 2021
C&M Baltazar Restaurants, LLC	January 1, 2021
C323 Operations LLC	January 1, 2021
Caddenhead Group Inc.	January 1, 2021
CAG Restaurant Group, Inc.	January 1, 2021
Canales Restaurant Corporation	January 1, 2021
CARL NELSON ENTERPRISES LLC	January 1, 2021
CC Pamphile, LLC	January 1, 2021
cfa the shops at lacantera	January 1, 2021
CfA@North Star Mall	January 1, 2021
CGN Shores Inc.	January 1, 2021
Chalmers Group, Inc	January 1, 2021
Chick-fil-A at Heights Corner FSR	January 1, 2021
Chick-fil-A at Northwest Crossing FSR	January 1, 2021
Chick-Fil-A Greenville In-Line DT	January 1, 2021
Chick-fil-A Harker Heights	January 1, 2021
Chick-fil-A Marketplace Bob Bullock	January 1, 2021
Chris Wright Enterprises	January 1, 2021
Cinnic Chicas	January 1, 2021
CKM Restaurant Group, Inc.	January 1, 2021
Clinton James Cowden dba Chick-fil-A Grapevine Mills	January 1, 2021
CM Restaurant	January 1, 2021
Community Lighthouse Restaurants Inc	January 1, 2021
Crisler Legacy ATX	January 1, 2021
Crown Heights Food Services	January 1, 2021
CWC Culinary Enterprises, Inc.	January 1, 2021
Daikonos Hospitality LLC	January 1, 2021
Darlene Kober	January 1, 2021
DeCola Enterprises	January 1, 2021
DeCola Restaurants, Inc	January 1, 2021
DEEM Restaurant Group Inc	January 1, 2021
DJ's Work-Wise Solutions, Inc	January 1, 2021
DLC Restaurant Group	January 1, 2021
DMBB380 LLC	January 1, 2021
DOCO Corp	January 1, 2021
Dogwinks, Inc	January 1, 2021
DotyClarke Hospitality LLC	January 1, 2021
Dreamchasers, llc	January 1, 2021
DTP Enterprises Inc	January 1, 2021
Dunn Restaurant Group	January 1, 2021
Dying About Real Bovine Special, LLC	January 1, 2021
DZ Restaurant Group, Inc.	January 1, 2021
E Flo Restaurant Group	January 1, 2021
Early Restaurant Services	January 1, 2021
Edorve Hospitality LLC	January 1, 2021
EM De Leon, Inc.	January 1, 2021

Emerald Restaurant Group	January 1, 2021
Emter and Sons, Inc	January 1, 2021
Encinia Restaurant Corporation	January 1, 2021
Eureka Chicken Inc.	January 1, 2021
EyeKey Hospitality Inc.	January 1, 2021
FALLS HOSPITALITY	January 1, 2021
FCPHassler Ventures, Inc	January 1, 2021
Fearless Pursuits, Inc.	January 1, 2021
Feytoria Investments LLC	January 1, 2021
Flying Saucer Chicken Inc	January 1, 2021
Four Ravens Inc.	January 1, 2021
FR500c INC	January 1, 2021
FSSAMF, LLC	January 1, 2021
Gary Kasprzak	January 1, 2021
GCP3C Investments LLC	January 1, 2021
GK Restaurant Group Inc.	January 1, 2021
Glenn Thigpen dba Chick-fil-a @ Beltway 8 @ West Road	January 1, 2021
Goolsby Fine Dining	January 1, 2021
Gregs Chicken Shack	January 1, 2021
GSGC Inc	January 1, 2021
H&B1977	January 1, 2021
H. Hatchings, INC.	January 1, 2021
H3 Hospitality	January 1, 2021
Hampton and I-20	January 1, 2021
hancock restaurant group llc	January 1, 2021
Handcrafted Restaurant Group, Inc.	January 1, 2021
Hatch Trick, Inc.	January 1, 2021
HB2 Restaurant Group	January 1, 2021
HDR On A Bun Inc.	January 1, 2021
High Plains Hospitality, LLC	January 1, 2021
High Wind Hospitality	January 1, 2021
Hospitable Chicken LLC	January 1, 2021
Houston Everett Group, LLC	January 1, 2021
Huggs Chicken, Inc	January 1, 2021
Hulahc Inc	January 1, 2021
ILIAC	January 1, 2021
Issachar of San Antonio	January 1, 2021
It's All Good Milco, LLC	January 1, 2021
J White Restaurant Enterprises, Inc.	January 1, 2021
J19 Restaurant Group	January 1, 2021
J3CS, Inc.	January 1, 2021
Jabberwocky Dynamics, Inc	January 1, 2021
JAHPC Inc.	January 1, 2021
Jason Evan Driscoll dba Chick-fil-A	January 1, 2021
JCZ Restaurant Group Inc	January 1, 2021
JDRussell Enterprises Incorporated	January 1, 2021
Jeremy Puckettdba Chick-fil-a Longview Mall	January 1, 2021

JH Chicken	January 1, 2021
JJWCC	January 1, 2021
JLQ Group, LLC	January 1, 2021
John Mark Maroney dba Chick-fil-A Coit & Spring Creek	January 1, 2021
Johnson Leadership Consulting	January 1, 2021
Jose F Martinez DBA @ Chick-Fil-A 10th St FSR	January 1, 2021
Julie Walker dba Chick--fil-A at South Loop Crossing	January 1, 2021
KandR Restaurant Group, INC.	January 1, 2021
Kavajack, Inc	January 1, 2021
Keller P22 Inc	January 1, 2021
Kendrick Skipper dba Chick-fil-A at Alden Bridge	January 1, 2021
Kerrville Chicken, Inc	January 1, 2021
KFRG INC.	January 1, 2021
Kosir Enterprises Inc	January 1, 2021
Lagniappe Hospitality	January 1, 2021
Lake Jackson DRG	January 1, 2021
Lamb & Company Inc.	January 1, 2021
LCJ Hospitality Inc.	January 1, 2021
LEAN ON 8, INC	January 1, 2021
LEROY Enterprises	January 1, 2021
Life Stewardship	January 1, 2021
Lubbock Hospitality, Inc.	January 1, 2021
Lucky Day Enterprises	January 1, 2021
Luke’s Umbrella LLC	January 1, 2021
M4 Restaurant & Hospitality Group, Inc	January 1, 2021
Magdaleno Restaurant Group, LLC	January 1, 2021
Magnified Plaid, Inc.	January 1, 2021
MAKE chicken Inc.	January 1, 2021
Manna Tree, Inc	January 1, 2021
MARKOFLIFE	January 1, 2021
MartinRae, Inc.	January 1, 2021
Mary Bauer Wade DBA Chick-fil-A Lufkin Mall	January 1, 2021
MATSCHIRHART, INC.	January 1, 2021
MaybeToday,Inc.	January 1, 2021
Mead & Co., Inc.	January 1, 2021
MEH Restaurants, LLC	January 1, 2021
Michael K. Lee Incorporated	January 1, 2021
Michaels Family Holdings, Inc.	January 1, 2021
Mike Tipton Restaurang Group, Inc.	January 1, 2021
MK Restaurant Group Inc.	January 1, 2021
MLF Hospitality, LLC	January 1, 2021
MM Gold Stream Group Inc.	January 1, 2021
MM Restaurant Group Inc.	January 1, 2021
Mmm! Chicken, Inc.	January 1, 2021
Moseley Restaurant Corporation	January 1, 2021
MT Arnett Restaurant Group	January 1, 2021
Mulkey Hospitality, Inc.	January 1, 2021

NBCEC, Inc	January 1, 2021
NEJ Restaurant Group, Inc.	January 1, 2021
Nest Egg Enterprises, Inc.	January 1, 2021
NMMasters, LLC	January 1, 2021
No Burgerz Inc.	January 1, 2021
North31stFSU/South31st FSU	January 1, 2021
nublet enterprises inc	January 1, 2021
October Eighth, Inc	January 1, 2021
ODAC47, Inc	January 1, 2021
Opportunities to Serve, Inc	January 1, 2021
Palmhurst Leadership LLC	January 1, 2021
Paul Kulas dba Chick-fil-A Addison FSU	January 1, 2021
PCR Enterprises, LLC.	January 1, 2021
Pearson Global Inc	January 1, 2021
Pfalz Inc	January 1, 2021
Pleasants Genuine Service, Inc.	January 1, 2021
Pollo Kid Restaurants Inc	January 1, 2021
Preston Road and Gary Burns	January 1, 2021
PS Lonestar Restaurants, Inc.	January 1, 2021
PSG Restaurants, Inc.	January 1, 2021
PTL Builders	January 1, 2021
Rabbit Twister Chicken, Inc.	January 1, 2021
Ragsdale Family Enterprises	January 1, 2021
RD Henckel Inc.	January 1, 2021
Red Alpha Holdings, Inc	January 1, 2021
Red E Restaurant Group, Inc	January 1, 2021
Reese-Leen Inc.	January 1, 2021
Relentless Leadership	January 1, 2021
RHGC&B, Inc.	January 1, 2021
RJS Hospitality Services, inc.	January 1, 2021
RLA Hospitality, Inc	January 1, 2021
Roadrunner Hospitality Inc.	January 1, 2021
Roger Clark Enterprises, Inc	January 1, 2021
Roye 2415, Inc.	January 1, 2021
RS2 Hospitality Group, Inc	January 1, 2021
RTTMC Enterprises	January 1, 2021
Rutwine Restaurant Group	January 1, 2021
S.H. Kennedy Group	January 1, 2021
SAAQW	January 1, 2021
Salmon Hospitality Group I c	January 1, 2021
SDADA Inc.	January 1, 2021
Sea Change Resources LLC	January 1, 2021
Sedeana	January 1, 2021
Self Service Hospitality Holdings LLC	January 1, 2021
Servant Light Eatery LLC	January 1, 2021
Serve Culture Inc	January 1, 2021
Shaffer Restaurant Group	January 1, 2021

Shepherd Hospitality Group, Inc.	January 1, 2021
Sher Chicken Inc	January 1, 2021
Sheridan Restaurant Group, Inc.	January 1, 2021
Sienko, Inc.	January 1, 2021
SONOAK Restaurant Services INC	January 1, 2021
Spirit LAAT	January 1, 2021
SRG, Inc.	January 1, 2021
Stellar Restaurants Inc.	January 1, 2021
Step by Step, Inc	January 1, 2021
SW Military	January 1, 2021
sykora family enterprises	January 1, 2021
Team Mendoza Inc	January 1, 2021
Ted Venecia DBA Chick-fil-a Sharyland	January 1, 2021
TEP Restaurant Group Inc.	January 1, 2021
TexAr Chicken LLC	January 1, 2021
Texas A-Dubb, Inc.	January 1, 2021
Texodus Inc.	January 1, 2021
The Durbin Group	January 1, 2021
The Herd Inc.	January 1, 2021
The Marroquin Group LLC	January 1, 2021
The Murray Partners, Inc.	January 1, 2021
The Other Side, Inc.	January 1, 2021
Thinline Group LLC	January 1, 2021
Thirteen-Two Hospitality, Inc	January 1, 2021
Thomas Restaurant Enterprises	January 1, 2021
Tovia-Garza Inc.	January 1, 2021
Trustworthy Business Initiatives, Inc.	January 1, 2021
Two Texas Chicken Kitchens Inc.	January 1, 2021
TwoBulls, Inc.	January 1, 2021
U.Sajid, Inc.	January 1, 2021
Valka Rice Inc.	January 1, 2021
VBales	January 1, 2021
W. M. ANTHONY, INC.	January 1, 2021
W.E, Hassler Enterprise Inc	January 1, 2021
Webber Restaurant Corporation	January 1, 2021
West End Futures LLC	January 1, 2021
WNBrown Enterprises, LLC	January 1, 2021
WSM Group	January 1, 2021
Wylie Restaurants, Inc	January 1, 2021
Younguns, Inc.	January 1, 2021
Zayas Restaurant Group, Inc.	January 1, 2021
ZD Cajun Turkey	January 1, 2021

In the event of amendment of this Appendix, a new Participating Employer Appendix may be attached to the Summary Plan Description in the place hereof without further amendment to the Summary Plan Description.

BENEFIT OPTION APPENDIX
Effective as of January 1, 2021

Fully Insured Benefit Type	Benefit Plan	Insurance Company	Claims Address	Claims Phone #
Medical	Prime PPO Plan	Aetna	PO Box 981106, El Paso TX 79998-1106	888-416-2277
Medical	Choice EPO Plan	Aetna	PO Box 981106, El Paso TX 79998-1106	888-416-2277
Medical	HDHP Plan	Aetna	PO Box 981106, El Paso TX 79998-1106	888-416-2277
Medical	Value HDHP Plan	Aetna	PO Box 981106, El Paso TX 79998-1106	888-416-2277
Medical	Kelsey Seybold Prime HMO	Aetna	PO Box 981106, El Paso TX 79998-1106	888-416-2277
Medical	Kelsey Seybold Choice HMO	Aetna	PO Box 981106, El Paso TX 79998-1106	888-416-2277
Medical	Kelsey Seybold Value HMO	Aetna	PO Box 981106, El Paso TX 79998-1106	888-416-2277
Medical	Texas Health Aetna Prime EPO Plan	Aetna	PO Box 981106, El Paso TX 79998-1106	800-261-2441
Medical	Texas Health Aetna Choice EPO Plan	Aetna	PO Box 981106, El Paso TX 79998-1106	800-261-2441
Medical	Texas Health Aetna HDHP Plan	Aetna	PO Box 981106, El Paso TX 79998-1106	800-261-2441
Medical	Texas Health Aetna Value HDHP Plan	Aetna	PO Box 981106, El Paso TX 79998-1106	800-261-2441
Medical	Memorial Hermann Prime EPO Plan	Aetna	PO Box 981106, El Paso TX 79998-1106	888-416-2277
Medical	Memorial Hermann Choice EPO Plan	Aetna	PO Box 981106, El Paso TX 79998-1106	888-416-2277
Medical	Memorial Hermann HDHP Plan	Aetna	PO Box 981106, El Paso TX 79998-1106	888-416-2277
Medical	Memorial Hermann Value HDHP Plan	Aetna	PO Box 981106, El Paso TX 79998-1106	888-416-2277
Medical	Seton Alliance Prime EPO Plan	Aetna	PO Box 981106, El Paso TX 79998-1106	888-416-2277
Medical	Seton Alliance Choice EPO Plan	Aetna	PO Box 981106, El Paso TX 79998-1106	888-416-2277
Medical	Seton Alliance HDHP Plan	Aetna	PO Box 981106, El Paso TX 79998-1106	888-416-2277
Medical	Seton Alliance Value HDHP Plan	Aetna	PO Box 981106, El Paso TX 79998-1106	888-416-2277
Group Life/AD&D	Employer Paid Life/AD&D	MetLife	PO Box 330, Warwick RI 02887-0330	800-638-5000
Supplemental Life/AD&D	Voluntary Life/AD&D	MetLife	PO Box 330, Warwick RI 02887-0330	800-638-5000
Employee Assistance Program	EAP	Aetna	EAPProviderConnectSupport@aetna.com	888-893-6584
Dental	Low PPO	Aetna	PO Box 14094, Lexington KY 40512-4094	877-238-6200
Dental	High PPO	Aetna	PO Box 14094, Lexington KY 40512-4094	877-238-6200
Vision	PPO	Aetna	PO Box 981106, El Paso TX 79998-1106	877-238-6200

In the event of amendment of this Benefit Option Appendix, a new Benefit Option Appendix may be attached to the Summary Plan Description in the place hereof without further amendment to the Summary Plan Description.