Wrap-Around Summary Plan Description for Insured Health Plan

Northeastern Pavers, LLC Insurance Plan Summary Plan Description

Caution: This document, together with the certificate of insurance booklets issued by (UHC Health Plan, Principal Dental, Vision and Life and Assurity) is your Summary Plan Description. If the certificate of insurance booklets are not attached, then this Summary Plan Description is not complete and you should contact Northeastern Pavers, LLC for a complete copy.

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1. Introduction

Northeastern Pavers, LLC maintains the Northeastern Pavers Group Insurance Plan (Plan) to provide insurance benefits to its eligible employees, their eligible spouses, and eligible dependents.

Benefits of the Plan are provided under insurance contracts entered into between Northeastern Pavers, LLC and **United Health Care, Principal and Assurity.**

You Must Enroll to Receive Benefits! You must affirmatively enroll to receive benefits under this Plan, as explained in Section 2 on Eligibility.

Summary of Benefits are located under each Benefit in Ease. You must read the summaries to understand your benefits.

Purpose of the Wrap-Around Document

Northeastern Pavers, LLC is providing this document to give you an overview of the Plan and to address certain information that may not be addressed in the Plan Summaries in Ease. This wrap around document, together with Summary of Benefits in Ease, along with the Enrollment Guide from Insource is the Summary Plan Description (SPD) required by ERISA. This wrap around document is not intended to give you any substantive rights to benefits that are not already provided by Summary of Benefits in Ease.

2. Eligibility and Participation Requirements

Eligibility

To determine whether you and your spouse and/or dependents are eligible to participate in the Plan, please read the eligibility information contained in the Summary of Benefits in Ease.

Requirements for Employee Eligibility

To be an eligible employee, (a) the minimum-hour requirement is 35 hrs. per week (averaged on an annualized basis); (b) there is a probationary period for new employees equal to 60 days. Insurance is effective on the first of the month following the probationary period.

Need for Enrollment: Time Limits

Eligible employees must complete enrollment online in the Ease portal to enroll themselves and/or their eligible spouses and dependents. New employees must enroll with certain time periods after being hired, as described in the attached certificate of insurance issued by **United Health Care, Principal and Assurity**. Otherwise, enrollment generally is limited to the annual open enrollment period that occurs before November of each year, as allowed in the certificate of insurance.

Special Enrollment Rights

In certain circumstances, enrollment may occur outside the open enrollment period, as explained in the Documents section in Ease. The Plan's Special Enrollment Notice also contains important information about the special enrollment rights that you may have, a copy of which was previously furnished to you.

Required Premium Payments

Employee is responsible for the following: For health insurance: Northeastern Pavers, LLC will cover at least 80% of the health plan premium; please refer to the Enrollment Guide for a schedule of benefits & premiums.

Dental Insurance: Employee is responsible for payment of full premium.

For Voluntary Life – Employee is responsible for payment of full premium-premiums are determined by age (see rate chart). For group term life- there is no cost to employee. Northeastern Pavers LLC pays the remainder of the premiums for these coverages. Northeastern Pavers LLC provides a schedule of the applicable premiums. Please refer to the Enrollment Guide for a schedule or premiums.

When Participation Begins
For information about when coverage begins, please read the eligibility information.

Termination of Participation

Your eligibility for Plan benefits terminates on the last day of the month in which you terminate employment with Northeastern Pavers LLC. Coverage will also terminate if you fail to pay your share of the premium, if you hours drop below the required threshold, if you submit false claims, and for certain other reasons described in the terms of the insurance policies. Coverage for our spouse and dependents stops when your coverage stops and for other reasons specified in the terms of the insurance plans (for example, divorce, dependent's attaining age limit, and other reasons). Benefits will also cease for employees, spouses, and dependents upon termination of the Plan.

Continuation of Coverage

If coverage for you, your eligible spouse, or your eligible dependents ceases because of certain "qualifying events" (e.g., termination of employment, reduction in hours, divorce, death, child's ceasing to meet the plant's definition of dependent) specified in a federal law called COBRA, then you, your eligible spouse, or your eligible dependents may have the right to purchase continuing coverage under the Plan for a limited period of time. For more information about COBRA rights, see COBRA in the Documents section of Ease. A copy of which has been previously furnished to you and your spouse (if covered under the plan).

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the Uniformed Services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage available pursuant to USERRA is included in the Documents section in Ease.

3. Summary of Plan Benefits

Benefits Provided

The Plan provides medical, dental, life and supplemental insurance to eligible employees and their eligible spouses and dependents. These benefits are provided under group insurance contracts entered into between Northeastern Pavers and United Healthcare, Principal and Assurity. A summary of the benefits provided under the Plan is set forth in the Enrollment Guide and Plan Descriptions in Ease. You must read the Plan Descriptions to understand your benefits!

Qualified Medical Child Support Orders

As explained in the insurance plan descriptions issued by **United Health Care, Principal and Assurity**, the Plan will extend benefits to an employee's non-custodial child, as required by any qualified medical child support order (QMCSO), under ERISA 609(a). The Plan has procedures for determining whether an order qualifies as a QMSCO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Human Resources Manager of Northeastern Pavers LLC.

4. Circumstances That May Affect Benefits

Your eligibility for Plan benefits terminates on the last day of the month in which you terminate employment with Northeastern Pavers LLC. Coverage will also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, if you submit false claims, and for certain other reasons described in the plan summaries from our providers. Coverage for your spouse and dependents stops when your coverage stops and for other reasons specified in the specific plan summaries (for example, divorce, dependent's attaining age limit, and other reasons). Benefits will also cease for employees, spouses and dependents upon termination of the Plan.

Depending on the reason that coverage was terminated, you and your covered spouse and dependents might have the right to continue coverage temporarily under COBRA and ESERRA.

The Plan may recover overpaid benefits through its rights to subrogation and reimbursement. These Plan rights are described in detail in the specific insurance plans.

Preexisting Conditions and other Exclusions

Other circumstances that can result in the termination, reduction, loss or denial of benefits (including exclusions due to preexisting conditions and exclusions for certain medical procedures) are described in the plan summaries in Ease. Please read the summaries carefully. The Plan's Initial Preexisting Condition Exclusion (PCE) Notice and the Plan's Special Enrollment notice contain important information about the exclusions due to preexisting conditions and special enrollment rights that you may have. Copies of these Notices were previously furnished to you and can also be found in the Documents section of Ease.

5. How the Plan is Administered

Plan Administration

The Plan is administered by Northeastern Pavers LLC (Plan Administrator).

Power and Authority of Insurance Company

The plan is fully insured. Benefits are provided under a group insurance contract entered into between Northeastern Pavers LLC and **United Health Care, Principal and Assurity**. Claims for benefits are sent to the Insurance Companies. The Insurance Companies, not Northeastern Pavers LLC is responsible for paying claims. The Insurance Companies are the Named Fiduciaries for benefit claims and are responsible for:

Determining eligibility for and the amount of any benefits payable under the Plan; and Providing the claims procedures to be followed and the claims forms to be used by eligible individuals pursuant to the Plan.

The Insurance Companies also have the authority to require eligible individuals to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Your Questions

If you have any general questions regarding the Plan, please contact human resources. However, if you have questions regarding eligibility for and/or the amount of any benefits payable under the Plan, please contact **United Health Care, Principal and Assurity.**

6. Amendment or Termination of the Plan

The Plan may be amended or terminated by a written instrument signed by the owners of Northeastern Pavers LLC or the Human Resources Manager, who is authorized to amend or terminate the Plan and to sing insurance contracts with the insurance Companies or other carriers, including amendments to those contracts. In addition, termination of the group insurance contracts entered into between Northeastern Pavers LLC and **United Health Care, Principal and Assurity**, will constitute termination of the Plan, unless Northeastern Pavers LLC exercises its sole discretion to obtain a substitute contact of insurance.

7. 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 Northeastern Pavers LLC to the effect that you will be employed for any specific period of time.

8. Claims Procedure

Benefit Claim

The Insurance Companies are responsible for evaluating all benefit claims under the Plan. The insurance Companies will decide you claim in accordance with its reasonable claims procedures, as required by ERISA. See the certificates of insurance issued by **United Health Care, Principal and Assurity** for information about how to file a claim and for details regarding the Insurance Company's claims procedures.

Appealing Denied Claim

If you 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 4.

Important Appeal Deadlines

If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a condition for bringing suit in a court). See certificates of insurance issued by **United Health Care, Principal and Assurity** for information about how to appeal a denied claim and for details regarding the Insurance Company's claims procedures.

9. General Information About the Plan

The name of the plan is Northeastern Pavers Health & Welfare Benefit Plan.

Type of Plan

The plan provides comprehensive Medical, Dental, Vision, Life/AD&D, Supplemental, Short-term Disability and 125 POP benefits and is considered a type of welfare benefit plan that is subject to the provisions of ERISA.

Plan Year

The plan year is December 1- November 30.

Plan Number

The plan numbers are as follows:

Health: United Health Care

Dental: Principal 1135078

Life: Principal 135078

Effective Date: 12/01/2024

The effective date is December 1.

Funding Medium and Type of Plan Administration

The plan is fully insured. Benefits are provided under a group insurance contract entered into between Northeastern Pavers, LLC and United Health Care, Principal Life Insurance, and Assurity. Claims for benefits are sent to United Health Care, Principal & Assurity (not Northeastern Pavers, LLC) are responsible for paying benefits. Note that **United Health Care, Principal, Assurity**, and Northeastern Pavers, LLC share responsibility for administering the plan, as discussed previously. Insurance premiums for employees are paid in part by the Plan Sponsor out of its general assets, and in part by employee pre-tax payroll deductions shall be used in their entirety prior to using Plan Sponsor contributions to pay for premiums under this plan. Any refund, rebate, dividend, experience adjustment, or other similar

payment under the group insurance contract entered into between Northeastern Pavers, LLC and **United HealthCare, Principal and Assurity** shall be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse Northeastern Pavers, LLC for premiums that it has paid.

Plan Sponsor

Northeastern Pavers, LLC
PO Box 566
Granbury, TX 76048
817-573-3809 (phone)
817-573-8016 (fax)

Plan Sponsor's Employer Identification Number

Northeastern Pavers, LLC employer identification number is 73-1115829

Insurance Companies Contact Information

HEALTH

United Health Care
785 Arbor Way
Arborcrest V, Suite 30
Blue Bell, PA 19422
www.uhc.com

DENTAL, VISION & LIFE

Principal 800-986-3343 www.principal.com

ASSURITY

Assurity Life Insurance Company
PO Box 82533
Lincoln, NE 68501-2533
402-476-6500 / 800-707-3987
www.Assurity .com

Agent for Service of Legal Process

Northeastern Pavers, LLC
PO Box 566
Granbury, TX 76048

817-573-3809 (phone)
817-573-8016 (fax)

Important Disclaimer

Benefits hereunder are provided solely pursuant to an insurance contract between the Plan Sponsor and the Insurance Companies. If the terms of this summary document conflict with the terms of the insurance contract, then the terms of the insurance contract will control, unless superseded by applicable law.

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 Securities 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 Northeastern Pavers, LLC 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 Human Resources manager of Northeastern Pavers, LLC, 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). Northeastern Pavers, LLC management may make a reasonable charge for copies.

Receive a summary of Plan's annual form 5500, if any required by ERISA to be prepared, in which case Northeastern Pavers, LLC, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPPA Rights

Under your COBRA rights you may 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 the SPD and the documents governing the Plan on the rules governing your COBRA coverage rights.

You may also be entitled to a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. you should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA, continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may require Northeastern Paver, LLC, as Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent 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 you have exhausted the claims procedures available to you under the Plan (discussed in claims procedures), you may file suit in a state or federal court.

If it should happen that the 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 if you are successful, the court may order the person you have sued to pay these costs and legal fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Human Resources Manager of Northeastern Pavers, LLC. 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 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 of 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.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event. If you are declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage

ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the plan administrator indicated in this notice.

HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information. ***As Required by Law***. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, a right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage) provided that you meet participation requirements. However, you must request enrollment within 30 days or any longer period that applies under the plan, after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the plan administrator mentioned above.

USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA), protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free From Discrimination and Retaliation

If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you: initial employment; reemployment; retention

in employment; promotion; or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Discrimination is Against the Law

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:

  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the plan administrator.

If your Company has fifteen (15) or more employees and you believe that The Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, refer to the Plan Administrator

for Grievance Procedures or if you need help filing a grievance can be filed in person, by mail, fax, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

QMCSO (Qualified Medical Child Support Order)

QMCSO is a medical child support order issued under state law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant is an alternate recipient. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer; know the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

FMLA

Family Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specific family and medical reasons if the employee has been with the company for one year, has worked at least 1250 hours during the prior 12 months and works in an area where there are at least 50 employees within 75 miles. Public agencies as well as public and private secondary schools are covered employers without regard to the number of employees employed. For additional details, visit the Department of Labor FMLA page.

Notify the Company when you have a qualifying leave such as birth or adoption of a child, a serious health condition, to care for a spouse, child or parent with a serious medical condition or for reservist or National Guard provisions related to you or an immediate family member leaving for military duty or being injured in active duty.

If you are on a qualified leave and any of the circumstances pertaining to your leave change, you must notify the company of the change.

Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information

With the key parts of the health care law that took effect in 2014, there is a new way to buy health insurance: **the Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by Northeastern Pavers.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

The Open Enrollment period is November 1st through December 15th of the year preceding the benefit plan year. Individuals may also qualify for Special Enrollment Periods outside of Open Enrollment if they experience certain events. (See Special Enrollment Period and Qualifying Life Event)

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.56% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. *Note: For plan years beginning in 2019 the income rate will change to 9.86%.*

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact your employer.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Information About Health Coverage Offered by Your Employer
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer Name: Northeastern Pavers
2. Employer Identification Number (EIN): 73-1115829
3. Employer Address: PO Box 566
4. Employer phone number: (817) 573-3809

5. City: Granbury
6. State: TX
7. ZIP code: 76048
8. Who can we contact about employee health coverage at this job: Missy Mussetter
9. Phone number for contact: (817) 573-3809
10. Email address: missy@northeasternpavers.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to: Eligible Employees.

Eligible employees are: Regular full-time employees who work an average of 30 more hours per week.

- With respect to dependents: We do offer coverage to all eligible dependents.

Eligible dependents are: Domestic Partner and/or legal spouse and dependent children and step-children of eligible employee.

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.*Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**

Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Northeastern Pavers

SECTION 125 PREMIUM ONLY PLAN

EFFECTIVE PLAN YEAR December 01, 2015

WHEREAS, Northeastern Pavers (the "Employer") sponsors one or more benefit plans that provide "qualified benefits" within the meaning of Section 125 of the Internal Revenue Code of 1986; and

NOW, THEREFORE, effective December 01, 2015 the Employer hereby adopts the Client Section 125 Premium Only Plan (the "Plan") to read as follows:

Article 1. *Introduction*.

1.1 Purpose of Plan. The Employer adopts the Plan. The purpose of this Plan is to provide Participants with a choice between cash compensation and Optional Benefit Coverages.

1.2 Cafeteria Plan Status. This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended, and is to be interpreted in a manner consistent with the requirements of Section 125. The Administrator is authorized to take any and all actions which it deems to be appropriate to maintain the Plan in compliance with the provisions of Section 125 of the Code as a "Cafeteria plan" including modification or revocation of elections hereunder.

Article 2. *Definitions*.

2.1 "Administrator" means the Employer or such other person or committee as may be appointed from time to time by the Employer to supervise the administration of the Plan.

2.2 "Adopting Employer" means an entity that adopts the Plan with the approval of the Employer. In order to be an Adopting Employer, the entity must be member of a controlled group of corporations with an Employer, as defined in Section 414(b) of the Code, all trades and businesses (whether or not incorporated) which are under common control, as defined in Section 414(c) of the Code, any member of an affiliated service group, as defined in Section 414(m) of the Code, and any other entity which is required to be aggregated with an Employer under Section 414(o) of the Code. The effective date of adoption by an Adopting Employer shall be the date specified in the resolution approving the adoption.

2.3 "Benefit Coverage Period" means the period during which a Participant is eligible under any Optional Benefit Coverage.

2.4 "Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any regulations there under and any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

2.5 "Coverage Period" means the Plan Year.

2.6 "Dependent" means such persons as are identified as dependents pursuant to the terms of the Optional Benefit Coverages made available to Participants.

2.7 "Eligible Employee" means an Employee who meets the eligibility requirements described in Section 3.1. An individual who does not meet the eligibility requirements in Section 3.1 will not be eligible to participate in the Plan under any circumstances.

2.8 "Employee" means any common law employee of the Employer or Adopting Employer. Employee will not include an independent contractor, consultants, leased employee, 2% shareholder of an S-Corporation or an individual who is self-employed (including partner) in accordance with Code Section 401(c). Any such determination of an individual's status as an Employee will be made solely by the Employer without regard to whether any determination by an agency, governmental or otherwise, or court concludes that such classification or characterization was in error.

2.9 "Employer" means Northeastern Pavers

2.10 "Key Employee" means any person who is a key employee, as defined in Code Section 416(i)(1), with respect to the Employer.

2.11 "Optional Benefit Coverages" means the coverage option(s) available to a Participant as set forth in the eligible benefit plans sponsored by Northeastern Pavers. In addition, to the extent Northeastern Pavers sponsors an eligible high deductible health plan, contributions to a health savings account by the Participant are included in Optional Benefit Coverages.

2.12 "Participant" means any individual who participates in the Plan in accordance with Article 3.

2.13 "Plan" means this cafeteria plan named the Northeastern Pavers Section 125 Premium Only Plan.

2.14 "Plan Year" means the twelve (12) month period commencing December 01 and ending November 30.

2.15 "Waiting Period" means the period during which an otherwise Eligible Employee is ineligible to participate in the Plan because he or she has not met the eligibility requirements in Article 3.

Article 3. *Participation*.

3.1 Commencement of Participation. Each Eligible Employee will become a Participant in this Plan on the date he or she satisfies the eligibility criteria for any Optional Benefit Coverage, subject to any applicable Waiting Period. Each Participant may elect Optional Benefit Coverages in accordance with, and subject to, the procedures set forth in Article 4 and such other procedures as may be established by the Administrator from time to time.

3.2 Cessation of Participation. A Participant will cease to be a Participant as of the earlier of (a) the date on which the Plan terminates, (b) the end of the Participant's Benefit Coverage Period, or (c) the date the

Participant ceases to be an Eligible Employee.

3.3 **Reinstatement of Former Participant**. A former Participant who meets the requirements for an Eligible Employee will become a Participant again if and when he or she becomes an Eligible Employee, subject to the completion of any applicable Waiting Period and upon proper enrollment as prescribed by the Administrator.

Article 4. *Optional Benefit Coverages.*

4.1 **Coverage Options**. Each Participant may choose under this Plan to receive his or her full compensation in cash or to have all or a portion of such compensation applied by the Employer toward the cost of the Optional Benefit Coverages elected by the Participant.

4.2 **Description of Optional Benefit Coverages**. While the election of Optional Benefit Coverages may be made under this Plan, the coverages and benefits elected by Participants will be provided not by this Plan but by the applicable benefit plans governing the Optional Benefit Coverages. The types and amounts of benefits available under each benefit plan, the requirements for participating in such benefit plan, and the other terms and conditions of coverage and benefits under such benefit plan are as set forth from time to time in such benefit plan's plan document.

4.3 **No Financial Responsibility for Optional Benefit Coverages**. In no event will the Employer or any of its affiliates or subsidiaries or any of their agents, directors, employees, consultants, insurers or owners have any obligation whatsoever to provide any actual benefits or cost reimbursements under Optional Benefit Coverages as a result of this Plan. The Employer's sole and exclusive obligation under this Plan is to collect from Participants compensation reductions elected hereunder.

4.4 **Election of Optional Benefit Coverages in Lieu of Cash**. A Participant may elect under this Plan, in accordance with the procedures described in Sections 4.5, 4.6 and 4.7, to receive one or more Optional Benefit Coverages to the extent available to the Participant under terms of such plans. If a Participant elects an Optional Benefit Coverage for a Coverage Period, the Participant is required to pay the employee portion of the cost of such coverage. Such share will be paid by a reduction in the Participant's regular compensation for the Coverage Period. In the event that the Participant's compensation during any pay period is insufficient in amount to pay the Participant's share of the monthly cost of such Optional Benefit Coverage by compensation reduction, the Employer has no responsibility under this Plan to cover, pay or advance on behalf of the Participant any such shortfall and the Participant must make immediate arrangements with the plan administrator of such Optional Benefit Coverage to pay such shortfall on an after-tax basis.

4.5 **Election Procedure**. Prior to the commencement of each Coverage Period, the Administrator will provide (or make available) a means of election to each individual who is eligible to become a Participant at the

beginning of the applicable Coverage Period, i.e. an "Open Enrollment". Each Participant who desires to elect an Optional Benefit Coverage available for the Coverage Period must specify in his or her election during Open Enrollment. The election will be effective as of the first day of the Coverage Period. The Participant must agree to a reduction in his or her compensation equal to the employee portion of the cost of the Optional Benefit Coverages elected. Each election must be made on or before such date and in such manner as the Administrator specifies. If a Participant fails to complete an election form for this Plan but elects an Optional Benefit Coverage, such Participant will be deemed to have elected to pay such employee portion of the cost of benefits on a pre-tax basis.

4.6 New Participants. Upon becoming a Participant mid-year, the Administrator will provide the means of election described in Section 4.5 to such participant. If the individual desires one or more Optional Benefit Coverages for the balance of the Coverage Period, the individual must specify in his or her election. The Participant shall agree to a reduction in his or her compensation equal to the cost of the Optional Benefit Coverages elected. Each election must be made on or before such date and in such manner as the Administrator specifies. Compensation reductions and elections will become effective as of the first day of the first Benefit Coverage Period specified by the Administrator following completion of the enrollment and election process.

4.7 Failure to Make Election.

(a) A new Participant's failure to make an election under Section 4.5 for this Plan on or before the due date specified by the Administrator for the Coverage Period in which he or she becomes a Participant but elects an Optional Benefit Coverage, such Participant will be deemed to have elected to pay the employee portion of the cost of the Optional Benefit Coverages on a pre-tax basis.

(b) An existing Participant's failure to make an election under this Plan relating to an Optional Benefit Coverage on or before the due date specified by the Administrator for any subsequent Coverage Period constitutes

(1) a re-election of the same coverage, if any, as was in effect just prior to the end of the preceding Coverage Period (to the extent such Optional Benefit Coverage remains available under the Plan), and

(2) an agreement to a reduction in the Participant's compensation for the subsequent Coverage Period equal to the cost of such coverage on the same basis (pre-tax or post-tax) as was previously elected.

4.8 Revocation or Change of Election by the Participant during the Coverage Period.

(a) Any election made under the Plan (including an election made through inaction under Section 4.7) will be irrevocable by the Participant during the Coverage Period except as otherwise provided in (b) through (k) below.

(b) With respect to an Optional Benefit Coverage, a Participant may revoke an election for the balance of the Coverage Period and, if desired, file a new election in writing if, under the facts and circumstances,

(1) a Change in Status occurs, and

(2) the requested revocation and new election satisfy the consistency requirements in Section 4.9 below.

For this purpose, a Change in Status includes the following events:

- Legal marital status. An event that changes a Participant's legal marital status, death of spouse, divorce, or legal separation or annulment.
- Number of dependents. An event that changes a Participant's number of dependents (as defined in Treasury Regulation 1.125-4(i)(3)), including birth, death, adoption or placement for adoption.
- Employment Status. An event that changes the employment status of the Participant, the Participant's spouse or dependent, including termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, and a change in worksite, as well as any other change in the individual's employment status that results in the individual becoming (or ceasing to be) eligible under the qualified benefit plans of the Employer.
- Requirements for Unmarried Dependents. An event that causes a dependent (as defined in Treasury Regulation 1.125-4(i)(3)) to satisfy or cease to satisfy the requirements for coverage under an Optional Benefit Coverage on account of attainment of age, student status, marital status or any similar circumstance.
- Residence. A change in the place of residence of the Participant or his or her spouse or dependent (as defined in Treasury Regulation 1.125-4(i)(3)).
- Significant Change in Cost. There is a significant change in the cost of an Optional Benefit Coverage.
- Coverage Curtailment. Coverage under an Optional Benefit Coverage is significantly curtailed.

- New or Eliminated Optional Benefit Coverage. A new Optional Benefit Coverage is offered or an Optional Benefit Coverage is eliminated.
- Change in Coverage under Spouse or Dependent's Plan. There is a change in coverage under the Participant's spouse's plan or Participant's dependent's (as defined in Treasury Regulation Section 1.125-4(i)(3)) plan.
- Open Enrollment in Spouse or Dependent's Plan. The enrollment period for coverage under the Participant's spouse's plan or Participant's dependent's (as defined in Treasury Regulation Section 1.125-4(i)(3)) plan occurs while the Participant's elections are in effect.
- Other Events. Such other events that the Administrator determines will permit the revocation of an election (and, if applicable, the filing of a new election) during a Coverage Period under regulations and rulings of the Internal Revenue Service.

(c) In the case of coverage under a group health plan, a Participant may revoke an election for the balance of the Coverage Period and file a new election that corresponds with the special enrollment rights provided in Code Section 9801(f) pertaining to HIPAA special enrollment rights.

(d) In the case of a judgment, decree or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires health coverage for a Participant's child who is a dependent (as defined in Treasury Regulation Section 1.125-4(i)(3)) of the Participant, a Participant may change his or her election:

(1) to provide coverage for the child under a health coverage required by the order, or
(2) to cancel a health coverage identified required by the order, if the order requires the Participant's spouse or former spouse or another individual to provide coverage for the child and that coverage is, in fact, provided.

(e) In the case of an accident or health plan Optional Benefit Coverage, a Participant may revoke an election in writing for the balance of the Coverage Period and file a new election in writing in order to cancel or reduce such Optional Benefit Coverage for the Participant and/or for one or more covered dependents (as defined in Treasury Regulation Section 1.125-4(i)(3)) of the Participant to the extent that such individual becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). In addition, if the Participant or any eligible dependent (as defined in Treasury Regulation Section 1.125-4(i)(3)) who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may file a new election in writing for the balance of the Coverage Period

to commence or increase an accident or health plan Optional Benefit Coverage.

(f) A Participant taking leave under the Family Medical Leave Act, if applicable, may revoke existing group health plan coverage and make such other election for the remaining portion of the Coverage Period as may be provided for under the Family Medical Leave Act.

(g) The Administrator may automatically change a Participant's contribution towards premiums to obtain Optional Benefit Coverages to reflect increase or decrease cost.

(h) Any application for a revocation or new election under this Section 4.8 must be made within the time specified by the Administrator following the date of the actual event and will be effective at such time as the Administrator prescribes, unless otherwise required by law.

(i) A Participant may revoke and or change an election relating to contributions to any health savings account on a prospective basis at least monthly or, if permitted by the Administrator, more frequently than monthly.

(j) A Participant may revoke an election for group health Optional Benefit Coverage prospectively for the remainder of the Coverage Period if the Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in such status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change (even if such reduction in hours does not result in the Participant ceasing to be eligible under the group health Optional Benefit Coverage), the revocation corresponds to the intended enrollment of the Participant (and any related individuals) in another plan that provides minimum essential coverage, and such new coverage is effective no later than the first day of the second month following the month that includes the date the group health Optional Benefit Coverage is revoked.

(k) A Participant may revoke an election for group health Optional Benefit Coverage prospectively for the remainder of the Coverage Period if the Participant is eligible for a special enrollment period to enroll in a qualified health plan through a marketplace or the Participant seeks to enroll in a qualified health plan through a marketplace during the marketplace's annual open enrollment period and the revocation of the election under the group health Optional Benefit Coverage corresponds to the intended enrollment of the Participant (and any related individuals) in a qualified health plan through a marketplace for coverage that is effective beginning no later than the day immediately following the last day of the revoked group health Optional Benefit Coverage.

4.9 Consistency Rules. A Participant's requested revocation and new election will be consistent with a change in status if the election change is on account of and corresponds with a change in status that affects the eligibility for coverage under a plan of the Employer or under a plan maintained by the employer of the

Participant's spouse or dependent (as defined in Treasury Regulation Section 1.125-4(i)(3)). A change in status that affects eligibility under the Employer's plan includes a change in status that results in the increase or decrease in the number of a Participant's family members or dependents (as defined in Treasury Regulation Section 1.125-4(i)(3)) who may benefit from coverage under the plan.

4.10 Changes by Administrator. If the Administrator determines, before or during any Coverage Period, that the Plan may fail to satisfy for such year any nondiscrimination or other requirement imposed by the Code or any limitation on benefits provided to Key Employees, the Administrator may take such action as the Administrator deems appropriate to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by highly compensated Employees (as defined by the Code for purposes of the nondiscrimination requirement in question) or Key Employees without the consent of such Employees.

4.11 Adjustment of Compensation Reductions. If the cost of an Optional Benefit Coverage provided to a Participant increases or decreases during a Coverage Period, including any increase or decrease due to a change in the Participant's salary, a corresponding change will be made in the compensation reductions of the Participant in an amount reflecting such increase or decrease, as determined by the Administrator to the extent the Administrator is advised of such change by the providers of such Optional Benefit Coverages which Participants may have elected.

4.12 Automatic Termination of Election. Any election made under this Plan (including an election made through inaction under Section 4.7) will automatically terminate at the close of the Benefit Coverage Period on which the Participant ceases to be a Participant in the Plan, although coverage or benefits may continue if and to the extent provided by such coverage. In the event such a former Participant again becomes a Participant within 30 days of ceasing to be a Participant, the elections previously in effect for the Participant will be automatically reinstated for the balance of the Coverage Period, except as otherwise elected by the Participant in accordance with Section 4.8.

4.13 Cessation of Required Contributions. Nothing in this Plan will prevent the cessation of coverage or benefits under any Optional Benefit Coverage, in accordance with the terms of such coverage, on account of a Participant's failure to pay the Participant's share of the cost of such coverage or benefits, through compensation reduction or otherwise.

4.14 Elections Via Other Media. The Administrator may, in its discretion, use any telephonic, electronic or other alternative media form that it deems necessary or appropriate for the election of Optional Benefit Coverages under the Plan.

4.15 Coordination with FMLA. Notwithstanding any other provision of this Plan, the Administrator may (a) permit a Participant to revoke (and subsequently reinstate) his or her election of one or more Optional Benefit Coverages under the Plan, and (b) adjust a Participant's compensation reduction as a result of a revocation or reinstatement to the extent the Administrator deems necessary or appropriate to assure the Plan's compliance with the provisions of the Family and Medical Leave Act of 1993 and any regulations pertaining thereto, if applicable.

4.16 Special Rule for Certain Covered Individuals. Notwithstanding anything in this Plan to the contrary, the cost of providing Optional Benefit Coverage to an individual as a Dependent of the Participant, where the covered individual is not a dependent of the Participant for purposes of Code Section 152 (as modified by Code Section 105(b) and IRS Notice 2004-79) will be paid by the Participant with after- tax contributions. Such costs will either be deducted by the Employer from the after-tax compensation of the Participant or, to the extent the cost of such Optional Benefit Coverage is paid from compensation reduction or any other form of Employer contribution, such contribution will be treated as taxable compensation received by the Participant and contributed by the Participant on an after-tax basis.

Article 5. *Administration of Plan.*

Administrator. The administration of the Plan will be under the supervision of the Administrator. It is a principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms without discrimination among participants. The Administrator has full discretionary power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Administrator's discretionary powers include, but are not limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

(a): To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;

(b): To interpret the Plan;

(c): To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(d): To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and

(e): To delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such delegation or designation to be in writing.

Any determination by the Administrator, or its authorized delegate, is final and conclusive on all persons. Notwithstanding the foregoing, any claim which arises under any Optional Benefit Coverage will not be subject to review under this Plan, and the Administrator's authority under this Section 5.1 does not extend to any matter as to which another administrator or entity is empowered to make determinations under such Optional Benefit Coverage.

Article 6. *Amendment and Termination of Plan.*

6.1 **Amendment of Plan**. The power to amend the Plan, in whole or in part, is vested in the Employer, which has the sole discretion to make all amendments to the Plan or any of its provisions. Such amendment will be effected by a written instrument signed by a duly authorized representative of the Employer, or his or her authorized delegate, and delivered to the Administrator.

6.2 **Termination of Plan**. The Employer has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the Employer will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan at any time, without liability, by a written instrument signed by a duly authorized representative of the Employer, or his or her authorized delegate, and delivered to the Administrator

Article 7. *Miscellaneous Provisions.*

7.1 **Information to be Furnished**. Participants will provide the Employer and the Administrator with such information and evidence, and will sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

7.2 **Limitation of Rights**. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against the Employer or the Administrator.

7.3 **Employment Not Guaranteed; No Vested Rights**. Nothing contained in the Plan, nor any action taken hereunder, will be construed as a contract of employment or as giving any Employee any right to be retained in the employ of the Employer. Nothing in this Plan is to be interpreted or construed in creating any vested rights in any benefits, coverage entitlements or compensations of any type.

7.4 **Unsecured General Creditor**. Participants, their beneficiaries, and all others have no rights or interests in any property of the Employer or its affiliates. Assets of the Employer will not be held under any trust for the benefit of Participants, their beneficiaries, or others or as collateral security for fulfilling of the obligations of the Employer under this Plan. All Employer assets will be unpledged and unrestricted assets of the Employer. Each Participant or beneficiary will be treated as a general unsecured creditor of the Employer and has no greater right to any assets other than an unsecured creditor.

7.5 No Liability for Action or Omission. Neither the Employer, nor any director, officer or employee of the Employer will be liable in any manner to any Participant, beneficiary or any other person claiming through them for any benefit or action taken or omitted in connection with interpretation and administration of this Plan.

7.6 Liability for Benefit Payments and Successorship. The Plan will not be automatically terminated by the Employer's acquisition by or merger into any other entity, but the Plan will be continued after such acquisition or merger if the successor employer elects and agrees to continue the Plan. All rights to amend, modify, suspend or terminate the Plan will be transferred to the successor as of the effective date of the merger or acquisition. This Plan and all of its terms will be binding upon such successors and the Employer's assigns.

7.7 Governing Law and Venue for Disputes. This Plan shall be construed in accordance with and governed by the laws of the State of Texas to the extent not superseded by federal law, without reference to Texas's conflict of laws provisions. Any action, dispute or challenge regarding the interpretation or enforcement of this Agreement must be brought and litigated in the United States District Court for Texas, if it otherwise has subject matter jurisdiction, or otherwise in the Circuit Court for State of Texas.

7.8 Correction of Defects. The Employer and Administrator may correct any defect, supply any omission, or reconcile any inconsistency in the Plan or any payment as it deems appropriate. If a Participant is overpaid or receives amounts, or has amounts paid on its or their behalf, which the Employer determines have been incorrectly paid to the Participant, the Participant must return such payments to the Employer upon demand. And, the Employer reserves the right to collect from, and offset, against the Participant's future wages from the Employer any amounts which the Employer determines have been overpaid or mistakenly paid to or for the benefit of any Participant.

7.9 Severability of Provisions. If any provision of this Plan is held invalid or unenforceable, such invalidity or unenforceability will not affect any other provisions hereof, and this Plan will be construed and enforced as if such provisions had not been included.

7.10 Acceptance of Terms. As a condition to receipt of benefits under the Plan and being permitted to participate under it, each Participant agrees to accept the terms of this Plan.

7.11 No Fiduciary Relationship. Nothing contained in this Plan, and no action taken pursuant to its provisions by the Employer or the Participants will create, or be construed to create a fiduciary relationship between the Employer, Administrator or any Participant or beneficiary.

IN WITNESS WHEREOF, Northeastern Pavers has caused this Plan to be executed in its name and on behalf of its officers there unto duly authorized this 1st day of December, 20 15.

Northeastern Pavers

By: _____

Title: VP

This document has legal and tax consequences. The Employer acknowledges that it is advisable to have this document reviewed by legal counsel prior to adoption of this document . The Employer acknowledges that HR Service, Inc., its affiliates, agents, employees and counsel have not been retained to provide any such review.

UNANIMOUS WRITTEN CONSENT

OF THE BOARD OF DIRECTORS OR OFFICERS OVERSEEING THE COMPANY OF

Northeastern Pavers

THE UNDERSIGNED, consisting of all members of the Board of Directors (the "Board") of Northeastern Pavers, a Texas corporation (the "Company") on this 1st day of December, 2015 do hereby waive any and all requirements for the holding of a meeting of the Board and in lieu of holding such meeting, do hereby take the following actions and adopt the following resolutions by signing this unanimous written consent:

WHEREAS, the Board desires to adopt the Northeastern Pavers Section 125 Premium Only Plan (the "Plan") effective December 01, 2015.

NOW THEREFORE BE IT RESOLVED, that the Plan is adopted and approved effective December 01, 2015;

And

FURTHER RESOLVED, that the President, Treasurer or Secretary is authorized and directed to take such actions as are appropriate and necessary to adopt the Plan; and

FURTHER RESOLVED, that the Secretary of the Corporation be and hereby is directed to file this Consent with the permanent records of the Corporation as the duly authorized act of the Board.



Northeastern Pavers

SECTION 125 PREMIUM ONLY PLAN

SUMMARY PLAN DESCRIPTION (SPD)

EFFECTIVE YEAR OF PLAN December 01, 2015

INTRODUCTION

Northeastern Pavers (the “Company") maintains the Northeastern Pavers Section 125 Premium Only Plan (the "Plan") for the benefit of eligible employees. The Plan is a "cafeteria plan" which offers the option of paying for qualified benefits on a pre-tax basis. This can result in significant savings.

This description summarizes the principal terms of the Plan in understandable terms so you can make informed decisions. It does not purport to be the complete Plan. Please read it carefully and keep it in a safe place for reference. A copy of the Plan document is available at the office of the Company for your inspection. In case of any conflict between the contents of the Plan and this summary, the provisions of the Plan control.

Benefits are provided separately by the individual benefit plan(s) that provide the optional benefits. Separate summaries or summary plan description(s) describes the benefits provided by the individual benefit plan(s).

ENROLLMENT AND ELIGIBILITY

Who is Eligible

All individuals, other than those excluded below, who are classified as employees and satisfy the eligibility criteria for any optional benefits offered by the Company which may be paid for on a pre-tax basis under this Plan. Individuals classified by the Company as independent contractors, consultants, leased employees, 2% shareholders of an S-corporation, self-employed individuals, and direct family members of the above mentioned are not "employees" under the Plan. Any determination of an individual's status as an employee will be made solely by the Company without regard to whether any determination by an agency, governmental or otherwise, or court concludes that such classification or characterization was in error.

Enrollment

Participation in the Plan for a period of coverage on a pre-tax basis is automatic unless you complete an election form declining such participation. A period of coverage means the Plan Year or, if you become an employee during a Plan Year, the portion of the Plan Year during which you are a Participant. You must complete and return the benefit election form to the Administrator by the date specified by the Administrator. If you fail to complete an election form by the prescribed time, you will be deemed to have elected to receive benefits under the Plan for that plan year (the calendar year) on a pre-tax basis. In order to receive benefits on an after-tax basis you must return the election form.

Leaves of Absence

A Participant who is on an unpaid leave of absence under FMLA, if applicable, for a period of more than thirty (30) days, may, at his option, continue any or all benefits under the Plan so long as he continues to make required premium payments with after-tax dollars. A Participant who is on any paid leave of absence must continue any and all benefits elected under this Plan and the same amount of contributions for those benefits will continue to be deducted from the Participant's paychecks during such absence.

Change in Elections

Once you elect coverage under this Plan, you may not change your coverage until the beginning of the next Plan year, unless coverage under the applicable benefit plan is significantly curtailed or ceases or unless you experience a "change in family status." If coverage under the applicable benefit plan is significantly curtailed or ceases, you may revoke your election under the applicable benefit plan and make a new election for the remaining period of coverage within 30 days (31 days if required by state law) after you receive notification of the curtailment of benefits from the Administrator. However, if the cost of the applicable benefit plans changes, you will not be entitled to revoke your election to receive such benefits and your contributions will be automatically adjusted to reflect the change in cost. If an increase in cost is considered a “significant cost change”, you may be allowed to make changes in that plans elections such as revoking your election to participate. If you experience a change in family status, you may modify your coverage under the Plan, consistent in family status. The following events are considered "changes in family status" for purposes of the applicable benefit plan:

- Your marriage;
- Your divorce, legal separation or annulment of your marriage;
- The death of your spouse or a dependent;
- The birth, adoption or placement for adoption of a child;
- Your dependent satisfies (or ceases to satisfy) dependent eligibility requirement under an applicable benefit plan of the Company;
- A change in coverage under another employer's plan for your spouse or dependent;
- The taking of or return from an unpaid leave of absence by you, your spouse or a dependent;
- The change in the place of residence or work of you, your spouse or a dependent;
- The change in the schooling or status of your spouse or a dependent for Plan purposes;
- The issuance of a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) that requires health coverage for a child either by you or your former spouse, but only if the event affects your need to be reimbursed for medical expenses on a pre-tax basis;
- The entitlement (or cessation of entitlement) to Medicare or Medicaid of you, your spouse or your dependent;
- A change in employment status from a position in which you were reasonably expected to work at least 30 hours per week to a position in which you are reasonably expected to work less than 30 hours per week together with your expected enrollment in other group health coverage.
- An election of coverage under a qualified health plan in a marketplace during a special enrollment period or a marketplace's annual open enrollment; or
- The open enrollment period for coverage under the Participant's spouse's plan or Participant's dependent's plan occurs while the Participant's elections are in effect.

To revoke an existing election and make a new election because of a change in family status, you must complete and deliver a new election form within thirty (30) days after the change in family status. The new coverage will generally be effective only prospectively.

Period of Coverage

The period of coverage under this Plan with respect to a Plan year will end the earlier of:

a. The date an Employee ceases to be an Employee;
b. The date the Employee fails to meet the eligibility requirements for the Plan; or
c. The date on which the Plan terminates.

Coverage periods under the benefit plans listed in Appendix A will be controlled solely by the individual benefit plan(s). You should consult the summaries or summary plan descriptions for the individual benefit plan(s) to determine the applicable coverage periods for the individual benefit plan(s).

PAYING FOR YOUR BENEFITS

You may acquire benefits under the Plan with pre-tax employee contributions. The pre-tax employee contributions are that portion of your compensation that you elect to apply to purchase benefits, rather than receive in cash. Pre-tax employee contributions are not subject to withholding for federal income or FICA taxes. Consequently, the amount withheld for taxes is reduced and employees who participate will, in most instances, see their take home pay increase. Here is an example of how it works:

> Your gross pay for a pay period is $1,000 and you are having $100 withheld to pay for benefits under the Plan. Currently, your withholding taxes are calculated based on $1,000. By applying pre-tax employee contributions to purchase benefits, your benefit costs are deducted first so that your taxes are computed on only $900. Less tax is withheld and the savings are yours.

Setting money aside as pre-tax employee contributions may mean a reduction in your Social Security benefits upon retirement or disability. However, the reduction most likely would be small.

AVAILABLE BENEFITS

Benefits

Under the applicable benefit plans offered by the Company, you are entitled to benefits for you and, if you so elect and the benefit plan provides family benefits, for your eligible family members. When you elect coverage under a benefit plan, you may pay your required contributions through this Plan on a pre-tax basis. The contributions you pay for such coverage will not be subject to federal or state income tax or FICA tax. You pay the applicable contribution for the level or type of coverage

(employee-only, employee and spouse, employee and children or family) you select. If the required contributions change, your pre- tax employee contributions are automatically adjusted to reflect such change. If the company sponsors a qualified high deductible health plan, you may elect to make pre-tax contributions to your health savings account.

APPENDIX A & ADDITIONAL INFORMATION

Name of Plan:	Northeastern Pavers Section 125 Premium Only Plan
Purpose of Plan:	The Plan allows employees to pay for coverage under eligible benefit plans sponsored by Northeastern Pavers on a pre-tax basis. In addition, to the extent Northeastern Pavers sponsors an eligible high deductible health plan contributions to a health savings account by the Participant can be paid on a pre-tax basis.
Effective Date:	December 01, 2015.
Sponsoring Employer:	Northeastern Pavers
Sponsoring Employer's EIN:	73-1115829
Adopting Employer:	
Adopting Employer's EIN:	
Administrator:	The Sponsoring Employer is the Administrator, responsible for the administration of the Plan and the agent for service of legal process. The Administrator has total discretion to determine the eligibility of employees to participate in the Plan, interpret the provisions of the Plan and establish rules and regulations for its operation
Service of Legal Process:	Northeastern Pavers HR Department
Plan Year:	December 01 - November 30
Funding:	The Company is not obligated to create a fund or segregate any assets to pay benefits under this Plan. The Plan shall not create any right on behalf of any Participant to any specific assets of the Company or in any way be construed so that the obligation to pay amounts under this Plan is secured or funded. All benefits payable under this Plan are nontransferable and non-assignable and any effort by a Participant to assign these benefits to any person shall be void.
Employees' Rights	Employees' rights to benefits under this Plan are intended to be legally enforceable, but neither the establishment of this Plan nor any amendment thereof will be construed as granting to any other person any legal or equitable right against the Company. This Plan shall be maintained for the exclusive benefit of employees.
Amendment:	The Plan may be amended or terminated by the Company, in whole or in part, at its discretion at any time.

Northeastern Pavers

SECTION 125 PREMIUM ONLY PLAN (the "Plan")

AUTOMATIC ENROLLMENT NOTICE

Pursuant to Section 125 of the Internal Revenue Code of 1986, the Employer will withhold the employee required contribution to the employer's applicable benefit plans during the Plan year on a pre-tax basis.

BENEFITS

Only benefits allowable under the Premium Only Plan provisions will qualify.

DURATION OF AGREEMENT

This agreement will remain in effect for the remainder of the Plan year, and will automatically renew each year thereafter unless a written request from you is presented to the employer, or if the employer ceases to provide the benefits elected by the Employee.

LIMITATIONS &INTENT

Nothing in this agreement changes the nature of your employment relationship. The sole purpose of this agreement is to exchange your cash compensation for the elected benefit(s) offered by the employer. This agreement is intended to comply with Section 125 of the Internal Revenue Code of 1986, as amended and any other applicable section of the Internal Revenue Code.

Your Enrollment in the Plan is Automatic.

No Signature Necessary, Sign ONLY if you are DECLINING TO PARTICIPATE in the Premium Only Plan.

Should you decide to pay more for your portion of the group insurance by using after-tax dollars, you may decline participation in the Plan by signing the following and presenting it to the employer.

I understand that participation in the Plan will allow me to save money by having my required contribution to applicable benefit plan coverage withheld on a pre-tax basis. However, I do not wish to participate in the Plan and will pay my portion of the premium using after-tax dollars.

_____ _____

Signature Date