SUMMARY PLAN DESCRIPTION

OF

T & D MORAVITS & COMPANY, LLC

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

This document was originally prepared as of February 1, 2026 and, as revised, completely revokes and supersedes all prior Summary Plan Descriptions.

SUMMARY PLAN DESCRIPTION

T & D MORAVITS & COMPANY, LLC

HEALTH REIMBURSEMENT ARRANGEMENT

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SUMMARY PLAN DESCRIPTION

OF

T & D MORAVITS & COMPANY, LLC

HEALTH REIMBURSEMENT ARRANGEMENT

INTRODUCTION

T & D MORAVITS & COMPANY, LLC is proud to present this description explaining the T & D MORAVITS & COMPANY, LLC HEALTH REIMBURSEMENT ARRANGEMENT (HRA) (the "Plan") to you. The well being of the employees and their families is important to us as the Employer and this program is designed specifically for that purpose. The entire of the cost of this plan is paid by the Employer. This description is designed to explain the program in understandable terms so you can make informed decisions. Please read it carefully and keep it in a safe place for reference. This plan is for you. There are values available for every employee who participates in the T & D MORAVITS & COMPANY, LLC group medical insurance plan and the Employer encourages you to make the most of them.

The purpose of this Health Reimbursement Arrangement is to reimburse Eligible Employees, up to certain limits, for their own, and if specifically listed in the Plan Operation section below, their covered Spouses' and Dependents' Medical Care Expenses. Reimbursements for Medical Care Expenses paid by the HRA Plan are generally excludable from taxable income. Although this SPD explains the important facts about the Plan, it does not replace the formal Plan Document. In the case of any inconsistency between the Plan Document and this SPD, the Plan Document will govern. Your rights under the Plan are legally enforceable, but oral statements relating to the Plan are not legally binding.

GENERAL INFORMATION

Name of Plan:	T & D MORAVITS & COMPANY, LLC HEALTH REIMBURSEMENT ARRANGEMENT (HRA)
Plan Number:	510
Plan Type:	Section 105 Health Reimbursement Arrangement
Plan Sponsor:	T & D MORAVITS & COMPANY, LLC 10511 Shaenfield Road San Antonio, Tx. 78254 210-688-3482
Employer Identification No:	74-2916787
Plan Administrator:	T & D MORAVITS & COMPANY, LLC
Plan Fiduciary:	William Roberts
Agent For Legal Process:	T & D MORAVITS & COMPANY, LLC/ Kathryn Angel 10511 Shaenfield Road San Antonio, Tx. 78254

210-688-3482

DEFINITIONS

"Effective Date" of the Plan is February 1, 2026

"Plan year" shall be the 12 month period ending on 12/31.

"Dependent" means the following:

For purposes of any Benefit Package Option offered by the Employer, "Dependent" shall be defined under the terms of the insured Benefits Package Option to which it relates, provided the individual also meets one of the criteria below:

1. your child (natural, step or adopted child or a foster child lawfully placed with you) who has not attained age 27 as of the end of the taxable year, regardless of whether the child resides with you, is a student or provides more than ½ of his/her own support, or

2. your child of any age if disabled and incapable of self-care; or

3. a child who is entitled to coverage under one of the Benefits Package Options due to a medical child support order; or

4. any individual (other than your spouse) who bears a relationship to you (provided the relationship does not violate local law), for whom you provide over ½ of his/her support for the calendar year, and who is not the dependent (for tax purposes) of any other individual.

For purposes of any Benefit Package Option offered by the Employer, "Dependent" shall be defined under the terms of the insured Benefits Package Option to which it relates, provided the individual also meets either 1 or 2 above.

PARTICIPATION

All Employees must meet eligibility requirements of the Plan in order to participate. You may then join the Plan on the "Entry Date" established for all employees.

The eligibility requirements for T & D MORAVITS & COMPANY, LLC employees: You will be eligible to participate in the Health Reimbursement Arrangement on the first of the month following 60 days of continuous fulltime employment. You must be regularly scheduled to work at least 30 hours per week. You must be a participant in the T & D MORAVITS & COMPANY, LLC group medical plan in order to participate in this Plan; your spouse and any Dependent must also be covered by the group medical plan in order to participate in this Plan.

The Entry Date for the Plan is the date eligibility requirements are met and continues 30 days past the entry date.

PLAN OPERATION

Once you become a Participant, the HRA Plan will maintain an HRA account in your name to keep a record of the amounts available to you for the reimbursement of certain eligible Medical Care Expenses. Your HRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest or accrue earnings of any kind. The HRA is linked to the group health plan of the Employer. You and/or your eligible family members will be reimbursed a maximum of $500 per transaction for a covered copayment or prescription drug expense. The maximum annual reimbursement per family

shall be $2,000 per plan year. You are not required to meet a deductible prior to being eligible to receive your reimbursement.

The Employer will contribute to your HRA Plan as follows: The Employer shall credit each covered employee's account with Employer contributions in the amounts listed above annually for the HRA.

Only "eligible expenses" can be reimbursed. To be eligible an expense must be:

1. A tax deductible medical expense not covered by insurance or reimbursed by any other source.
2. An expense incurred by you (or your spouse or your dependent, if applicable). An expense shall be considered "incurred" when the service was rendered, and not when you are formally billed, charged for or pay for the expenses.
3. An expense incurred during the plan year, and submitted for reimbursement not later than 90 days after the end of the plan year.
4. An in-network copayment or prescription drug expense covered under the Employer-sponsored group health plan, as specified in the Adoption Agreement.

Examples of eligible expenses include in-network copayments and prescription drug expenses covered under the Employer-sponsored group health plan, subject to the Plan's $500 per-transaction limit, $2,000 annual maximum, and all other Plan terms.

As you incur eligible expenses, you may obtain reimbursement by using the HRA debit card or by submitting a claim form to the administrator. Claims and debit-card transactions are subject to the Plan Administrator's procedures. Or or after October 1, 2026, once the applicable debit-card configuration is activated, eligible debit-card transactions of $500 or less at merchant categories designated by the Plan Administrator may be processed under the Plan Administrator's debit-card procedures without Participant submission of additional documentation at the time of the transaction. Other transactions may require supporting documentation describing who received the service, when the expense was incurred, the type of expense, the amount of the expense and who was paid. Supporting documentation must come from the third-party provider of the service; the best supporting documentation is an EOB (Explanation of Benefits) from your insurance carrier. Cash register receipts, canceled checks, credit card slips or credit card bills will not be accepted. This administrative processing procedure does not change eligible expenses, the $500 per-transaction limit, or the $2,000 annual maximum, and it does not waive any substantiation requirement imposed by applicable federal law. The Plan Administrator may require subsequent documentation, correction, or repayment if a transaction is later determined to be ineligible or otherwise fails to satisfy applicable substantiation requirements.

Manual claims must be submitted on the forms provided by the Employer; debit-card transactions are processed under the Plan Administrator's debit-card procedures. You are responsible for making certain, to the best of your ability, that all expenses submitted for reimbursement or paid with the HRA debit card are eligible expenses. The Plan Administrator may require subsequent documentation, correction, or repayment if a transaction is later determined to be ineligible. Claims will be paid up to the full amount available under your account for the plan year. Once you have reached that amount no further reimbursements will be made.

While an expense must be incurred during the plan year to be eligible, claims do not have to be reported during the plan year. ***Claims submitted during the 90 day period after the end of the plan year or your last day of employment, whichever is earlier, will be accepted for payment.*** Claims submitted later than that will not. However, if your termination is due to retirement, you may continue to incur and submit claims for the balance of the calendar year. The earlier you submit your claims, however, the earlier you will be reimbursed.

YOUR ACCOUNT DOES NOT ROLL OVER AT THE END OF THE PLAN YEAR.

ADMINISTRATIVE AUTHORITY

The Employer or Administrator may terminate or modify Plan benefits at any time, subject to the provisions

of any insurance contracts providing benefits described herein. We will not be liable to you if an insurance company fails to provide any of the benefits.

TERMINATION OF EMPLOYMENT

Should you leave our employ during the plan year, your right to benefits will be determined in the following manner:

Under this Plan, you will be able to claim reimbursement for expenses incurred prior to your termination of employment. Claims must be received no later than 90 days following your date of termination. You may also have health continuation rights, discussed further below.

COBRA CONTINUATION COVERAGE RIGHTS

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of healthcare flexible spending account coverage under the Plan. **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your HRA coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their coverage under the HRA. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

You cannot elect COBRA coverage under the HRA unless you have also elected COBRA coverage under the health plan. However, you can elect COBRA coverage under the health plan and not under the HRA. If you elect COBRA coverage under the health plan there will be a monthly premium equal to 102% of the cost of normal coverage under the health plan. If, in addition, you elect COBRA coverage under HRA, there will be an additonal monthly premium equal to 102% of the employer's actuarial cost of providing coverage under the HRA.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of health plan coverage. The materials you have received in connection with the health plan the Employer offers (and in which you must participate as a condition of participating in this HRA plan) discuss COBRA continuation coverage with respect to the health plan. If you cease to participate in the health plan, you will also lose coverage in the HRA offered through this Plan. The discussion of COBRA continuation coverage in this summary plan description applies to the HRA coverage, although the same rules apply to COBRA continuation coverage related to the health plan and to this Plan. Under either plan, COBRA continuation coverage is available 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 the HRA 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 the HRA 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 the HRA 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 the HRA 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 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 Plan 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 Administrator within 60 days after the qualifying event occurs (within 30 days of loss of Social Security disability status). An untimely Qualified 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. 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 attached to 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 Plan 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 Plan 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 Plan 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. If you do not receive a response from the Plan Administrator within 14 days of mailing the notice, you must contact Victoria Hernandez immediately in writing to determine the status of your COBRA claim.

Second-Chance COBRA Election

If you are an employee eligible to receive Trade Adjustment Assistance (TAA) benefits, and you (i) lost HRA 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 Plan Administrator and returning it to the Plan 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. The COBRA Election Notice will provide you with additional information regarding electing COBRA during this second-chance period.

The Trade Act of 2002 allows certain individuals who become eligible for trade adjustment assistance and certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) to take advantage of the Health Coverage Tax Credit. Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of a specified percentage of premiums paid for qualified health insurance, including continuation coverage and, under COBRA, you may be eligible for an extension of COBRA continuation coverage if your COBRA continuation coverage would otherwise end on or after November 20, 2011. Assistance Eligible Individuals who elected the premium reduction under ARRA will not be eligible for the Health Coverage Tax Credit for the months in which they receive a premium reduction.

How Is COBRA Coverage Provided?

Once the Plan 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date

on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

The COBRA continuation coverage period that applies to certain health care reimbursement plans may not be the same as the COBRA continuation period that applies to other health care benefits as described above, but may end as of the last day of the Plan Year in which the qualifying event occurs. This is discussed further in the subsection entitled *COBRA Coverage for Employees Participating in a Health Care Reimbursement Plan*, below.

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 Plan 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 Plan 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 Plan Administrator. A copy of the determination by the Social Security Administration must be attached to 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.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan 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 0900 . (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series; generally not applicable to a plan with 100 participants or less.) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report (generally not applicable to a plan with 100 participants or less).

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

MICHELLE'S LAW

Michelle's Law applies to 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 health plan, including MERP or HRA, 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 (1) covered under the plan and (2) 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:

1. begins while the child is suffering from a serious illness or injury
2. is medically necessary
3. 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:

1. 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
2. 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.

COORDINATION WITH COBRA CONTINUATION COVERAGE

If your child is eligible for Michelle's Law's continued coverage and loses coverage under the Plan at the end of the continued coverage period, continuation coverage under COBRA will be available at the end of Michelle's Law coverage period and a COBRA notice will be provided at that time.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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 Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

CLAIMS PROCEDURE - GENERAL

Reimbursement. With respect to all benefits provided under the Plan through reimbursements, a claim for benefits shall be made by filing a written request with the Plan Administrator, on such forms as the Plan Administrator shall establish, or by using the HRA debit card in accordance with the Plan Administrator's debit-card procedures. The Plan Administrator may require that the claim or debit-card transaction be supported by receipts or other evidence substantiating the amount of the expenditure and the character of the claim. You may not use canceled checks, charge card receipts or cash register receipts as substantiation. The Plan Administrator will review the claim and within a reasonable period of time (not to exceed 30 days after the receipt of the claim) notify the claimant of the disposition of the claim if the claim is honored, then the Plan Administrator will make payment to the Participant for the amount of the claim. If the Plan Administrator denies the claim in whole or in part, it will provide written notice to the claimant of the denial of the claim and such notice will set forth:

IN THE CASE OF ANY BENEFIT PROVIDED UNDER THE PLAN BY REIMBURSEMENT, ALL CLAIMS FOR REIMBURSEMENT FOR EXPENSES INCURRED WITH RESPECT TO A PLAN YEAR MUST BE SUBMITTED TO THE PLAN ADMINISTRATOR NO LATER THAN 90 DAYS FOLLOWING THE END OF THE PLAN YEAR OR YOUR LAST DAY OF EMPLOYMENT, WHICHEVER IS EARLIER. CLAIMS SUBMITTED AFTER THAT DATE WILL NOT BE PAID.

Any request for a review of a denied claim must be made in writing within 60 days following the receipt by the claimant of written notification of denial of his claim. The Plan Administrator shall review any denied claim upon timely filed request of the claimant within 60 days after receipt of a written request for review, unless special circumstances require an extension of time for processing, in which case the decision shall be rendered as soon as possible but not later than 120 days after receipt of the written request for review. If such an extension of time for review is required because of special circumstances, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension. The decision on review will be in writing, will include specific reasons for the decision and will be furnished to the claimant within the time indicated above. If the decision on review is not furnished within such time, the claim shall be deemed denied on review. In any cases in which a Participant establishes that he will incur fixed periodic expenses with respect to which the Participant elected to be reimbursed under the Plan, the Plan Administrator may, upon receipt of such assurances and substantiation of those expenses as the Plan Administrator deems appropriate, make periodic reimbursements to the claimant as those expenses are incurred. In such cases, the Plan Administrator may, in its sole discretion, excuse the Participant from making claims for reimbursement for some or all of those expenses.

If the you are denied a Benefit under the Plan due to questions regarding the your eligibility or entitlement for coverage under the Plan, you may request a review upon written application to the Plan Administrator.

You or your Authorized Representative, may request access to all relevant documents in order to evaluate whether to request review of an Adverse Benefits Determination and if review is requested, to prepare for such review.

An appeal of an Adverse Benefits Determination must be made in writing within 180 days upon receipt of the notice that the claim was denied. If an appeal is not made within the above referenced timeframe all rights to appeal the Adverse Benefits Determination and to file suit in court will be forfeited. A written appeal should include: additional documents, written comments, and any other information in support of the appeal. The review of the Adverse Benefits Determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The Plan Administrator, within a reasonable time, but no later than 60 days after receipt of the request for review, will decide the appeal. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided. If the decision on review affirms the initial denial of the claim, a notice will be provided which sets forth:

The specific reasons for the decision on review;

The specific Plan provisions on which the decision is based;

A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

Appropriate information on the steps to take to appeal the Plan Adminstrator's Adverse Benefits Determination, including the right to submit written comments and have them considered, and the right to review, upon request and at no charge, relevant documents and other information, and the right to file suit under ERISA, where applicable, with respect to any Adverse Benefits Determination after the final appeal of the claim.

If a you fail to file a request for review in accordance with the claims procedures outlined herein, such Participant shall have no rights of review and shall have no right to bring action in any court. The denial of the claim shall become final and binding on all persons for all purposes

OPT OUT OF PLAN AND WAIVE FUTURE REIMBURSEMENTS

An Eligible Employee (including an Eligible Employee who has terminated employment) is permitted to permanently opt out of and waive future reimbursements from the Plan at least annually and, upon termination of employment, either the remaining reimbursable amounts in the Plan are forfeited or the Eligible Employee is permitted to permanently opt out of and waive future reimbursements from the Plan. This opt-out feature is available to you in case you wish to obtain a health insurance policy in the Insurance Marketplace or Exchange and would otherwise be eligible for a premium tax credit or other financial assistance through the Marketplace. You would <u>not</u> be eligible for a premium tax credit or other financial assistance if the Employer has offered you affordable health coverage that has minimum value, so it would be advisable for you to check with the Employer and with the Marketplace before opting out of the Plan and waiving any future reimbursements for the year.

PRIVACY OF HEALTH INFORMATION

This section describes the medical information privacy practices of the Medical Expense Reimbursement Account portion of the Plan, and that of any third party that assists in the administration of the Plan's group health claims, and is effective April 14, 2004, or the effective date of the Plan, whichever is later. For a more complete explanation, see the "Notice of Privacy Practices" which was given to you in connection with these rights. Questions about the Plan's privacy practices should be addressed to the Plan's Privacy Official who is Kathryn Angel and who may be contacted at T & D MORAVITS & COMPANY, LLC 10511 Shaenfield Road San Antonio, Tx. 78254 210-688-3482.

Our Pledge Regarding Medical Information

The Plan is committed to protecting medical information about you. The Plan may disclose protected health information to the Employer under limited circumstances, although this information will be disclosed only upon the receipt of a certification by the Employer that the Plan documents have been amended to incorporate the privacy provisions, and that it will abide by them.

The Plan may disclose summary health information to the Employer for the purposes of obtaining premium

bids, insurance coverage, or modifying, amending, or terminating the Plan.

The Plan may disclose protected health information to carry out Plan administration functions that are consistent under applicable law. The Plan may not disclose protected health information to the Employer for the purpose of employment-related actions or decisions in connection with other benefits or employee benefit plans of the Employer.

A limited number of employees of the Employer will have access to protected health information for the purposes of carrying out Plan administration functions in the ordinary course of business.

How the Plan May Use and Disclose Medical Information About You

The following categories describe different ways that the Plan uses and discloses protected health information. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

For Treatment. The Plan may use or disclose medical information about you to provide you with medical treatment or services by providers. The Plan may disclose protected health information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you at the hospital. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

For Payment. The Plan may use and disclose protected health information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may share protected health information with a utilization review or precertification service provider. Likewise, the Plan may share protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. The Plan may use and disclose protected health information about you for other Plan operations which are necessary to run the Plan. For example, the Plan may use protected health information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

As Required By Law. The Plan will disclose protected health information about you when required to do so by federal, state or local law. For example, the Plan may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

To Avert a Serious Threat to Health or Safety. The Plan may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose protected health information about you in a proceeding regarding the licensure of a physician.

To Facilitate Claims Under Employer Plans. Your health information may be disclosed to another health plan maintained by the Employer for purposes of paying claims under that plan. In addition, medical information may be disclosed to the Employer to administer benefits under the Plan, such as to determine a claims appeal.

Provide You With Information. The Plan or its agents may contact you to remind you about appointments or provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Organ and Tissue Donation. If you are an organ donor, the Plan may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplants, or to an organ donation bank to help with organ or tissue donation.

Military and Veterans. If you are a member of the armed forces, the Plan may release protected health information about you as required by military command authorities. The Plan may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Public Health Risks. The Plan may disclose protected health information about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or to notify the appropriate government authority if the Plan believes a participant has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Plan may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Plan may disclose protected health information about you in response to a court or administrative order. The Plan may also disclose protected health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan may release protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, the Plan is unable to obtain the person's agreement; about a death the Plan believes may be the result of criminal conduct; about criminal conduct at the hospital; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. The Plan may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release protected health information about you to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may release protected health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Your Rights Regarding Medical Information About You

You have the following rights regarding protected health information the Plan maintains about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. If you request a copy of the information, the Plan may charge a fee for the costs copying, mailing, or other supplies associated your request. The Plan may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or health care operations. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information the Plan discloses about you to someone who is involved in your

care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had. The Plan is not required to agree to your request however.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail. The Plan will not ask you the reason for your request. The Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You will not be retaliated against for exercising the privacy rights described above.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by the above discussion or the laws that apply to the Plan will be made only with your written permission. If you provide the Plan permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that the Plan is unable to take back any disclosures the Plan has already made with your permission, and that the Plan is required to retain its records of the benefits that the Plan provided to you.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Each group health plan must provide benefits in accordance with the applicable requirements of any qualified medical child support order. A "medical child support order" (MCSO) is an order, decree, or judgment of a court of competent jurisdiction which (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 "qualified medical child support order" (SMCSO) is a medical child support order which (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.

The order must clearly state—

(i) 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),

(ii) 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,

(iii) The period to which such order applies, and

(iv) Each plan to which such order applies.

Certain procedural requirements are prescribed. 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 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.

NO GUARANTEE OF BENEFITS

Neither the Trustee, nor the Employer, in any way guarantees the payment of any benefit or amount which may become due pursuant to the terms of this Agreement to any Participant, Retired Participant, Terminated Participant or Beneficiary thereof. Neither the Trustee nor the Employer guarantees the payment by any issuing insurance company of any benefit or amount that may be due under any contract.

The establishment of this Plan does not give any Participant or other person any legal right against the Employer or any of its officers or employees or against the Trustee or any insurance company except as herein provided or provided in the terms of any insurance contract. Under no circumstances shall the terms of employment of any Participant be modified or in any way affected by the enactment of this Plan, nor shall participation in this Plan give any employee the right to be retained in the Employer's service or any right or interest in the Trust other than as is herein provided.

THIS DESCRIPTION DESCRIBES THE PROVISIONS, TERMS AND CONDITIONS OF THE BENEFITS OFFERED BY THIS PLAN IN GENERAL, EASY TO READ LANGUAGE. IT IS INTENDED TO DESCRIBE THE PROGRAM AS ACCURATELY AS POSSIBLE IN A READILY UNDERSTANDABLE MANNER.

THE HEALTH REIMBURSEMENT ARRANGEMENT IS DESCRIBED IN GREAT DETAIL IN A PLAN DOCUMENT OR INSURANCE CONTRACT. SHOULD THERE BE ANY DISCREPANCY BETWEEN THE DESCRIPTIONS IN ANY OF THE PLAN DOCUMENTS OR INSURANCE CONTRACTS AND THOSE IN THIS DESCRIPTION, THE TERMS OF THOSE DOCUMENTS AND CONTRACTS WILL GOVERN IN ALL INSTANCES. THEY ARE AVAILABLE AT THE EMPLOYER'S OFFICES FOR YOUR REVIEW AT ANY TIME.