

2027 BENEFITS

4-Horn®
INVESTMENTS LP

WELCOME TO YOUR BENEFITS

Our most important asset is our people. That's why 4-Horn Investments offers a comprehensive benefits program to meet all your needs. Review this guide to learn about everything provided to you and to determine which benefits are best for you and your family.

You will find many resources outlined in this guide available during enrollment and throughout the year to help you make the most of your benefits plans and answer your questions.

The health care coverage you elect begins with your initial eligibility date and continues through the end of the enrollment year. 4-Horn Investments health care benefit year begins January 1st and ends December 31st. You may also enroll or change your benefits during the annual Open Enrollment period, generally in November, for a January 1st effective date.





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CONTACTS & RESOURCES

Find more details about the benefits offered to you by contacting your insurance carrier or logging in to ADP. Register on the insurance carrier websites to access plan information, including your ID cards, coverages, claims, network providers, and more. Download the carrier apps to access your benefits information anytime, anywhere from your mobile device.

If you have questions about or need assistance with enrolling, or want more detail about your benefits, you may contact Human Resources or visit 4hornemployeebenefits.com:

Nicole Whitfield
Human Resources
nwhitfield@4hornmgmt.com

INSURANCE CARRIER WEBSITE AND APPS

Registering with the insurance carrier gives you instant access to valuable resources.

In most cases, you can access the following:

- Specific plan details
- ID cards
- Find an in-network provider or health facility
- Your claims history
- Cost comparison tools
- Price medications
- Other tools and resources

BENEFIT	Carrier	Group #	Phone	Website
Medical	BCBS of TX	400945 400946	800-599-2583	bcbstx.com
Virtual Visits	MDLive	N/A	888-680-8646	mdlive.com/bcbstx
HSA	HSA Bank	N/A	855-731-5221	hsabank.com
FSA and HRA	WEX	35806	866-451-3399	wexinc.com
Dental	BCBS of TX	330957	800-247-4695	bcbstx.com
Vision	BCBS of TX	VF027068	800-247-4695	eyemed.com
Life and AD&D	Symetra	01021030100	877-377-6773	symetra.com/myGO
Disability	Symetra	01021030100	877-377-6773	symetra.com/myGO
Worksite Benefits	Symetra	01021030100	877-377-6773	symetra.com/myGO
Wellness Program	WellWorks	13195	800-425-4657	wellworksforyoulogin.com

ELIGIBILITY & ENROLLMENT

All regular full-time employees working at least 30 hours per week are eligible for benefits. As a new hire, you are eligible on the first day of the month following 30 days of employment. Additionally, you may enroll during the annual Open Enrollment period for a January 1st effective date.

Who Can Enroll

You may enroll the following dependents in our group benefit plans:

- Your legal spouse
- Your natural, adopted, or stepchildren living with you, or any other children whom you have legal guardianship, up to age 26
- Unmarried children of any age if disabled and claimed as a dependent on your federal income taxes

When You Can Enroll

You can enroll in benefits:

- During your initial new hire eligibility period
- During the annual Open Enrollment (OE) period for a January 1st effective date

If you fail to enroll within the timeframe given, you will not be able to elect benefits again until the next OE period, and you will not have coverage. Please make your elections on time, or you may experience a delay in using your benefits.

Termination of Coverage

Benefits coverage will be terminated:

- On the last day of the month following the termination or resignation date if you leave your job
- On the last day of the month following their date of birth when a covered dependent reaches age 26

MAKING CHANGES TO YOUR BENEFITS

Outside of your initial new hire or the annual Open Enrollment period, changes to your benefits can only be made throughout the year within 30 days of a qualifying life event. Examples of the most common events include:

- Marriage or divorce
- Birth or adoption of an eligible child
- Death of a covered dependent
- Change in your or your spouse's work status that affects your benefits
- Change in residence that affects your eligibility for coverage
- Change in your child's eligibility for benefits
- Receipt of a Qualified Medical Child Support Order (QMCSO)

To see a complete list, or to report an event, contact Human Resources. Documentation may be required. If you fail to report a life event and supply the necessary documentation, you will be required to wait until the next annual enrollment period to make changes.





MEDICAL BENEFITS

4-Horn Investments employees have the choice between three medical plans offered through BCBS of TX: traditional PPO plans, and a High-Deductible Health Plan (HDHP) that is compatible with a Health Savings Account (HSA). All plans offer services through the Blue Choice network.

With the PPO plans, you pay a copay for office visits and other covered services are paid by the plan coinsurance once you reach your deductible. HDHP participants are eligible to open a Health Savings Account to set aside pre-tax dollars to pay for their deductible and other out-of-pocket healthcare costs. See pages 10-11 for more information on tax-advantaged savings accounts that can help you save on healthcare expenses.

All plans offer preventive care visits covered at 100%, an out-of-pocket maximum to protect you should a catastrophic event occur, and out-of-network coverage if needed. Although out-of-network coverage is available, using in-network providers will save you money. You can find BCBS of TX network providers online at bcbstx.com and search the Blue Choice network.

Preventive Care

All BCBSTX medical plans include preventive care services, including immunizations, covered 100% under your medical insurance, meaning no copays or deductibles will apply when an in-network provider delivers the covered services. Preventive exams can detect if you are at risk for a chronic disease that may be preventable. Talk to your healthcare provider to determine which screenings

MEDICAL PLAN COMPARISON

PLAN HIGHLIGHTS	HSA Plan	Silver Plan	Gold Plan
	In-Network	In-Network	In-Network
Employer HSA/ HRA Contribution Individual / Family (bi-weekly)	$25 / $75	$25 / $50	N/A
Annual Deductible Individual / Family	$5,000 / $10,000	$3,000 / $9,000	$1,000 / $3,000
Coinsurance Member Pays	0%	30%	20%
Annual Out-of-Pocket Max Individual / Family	$5,000 / $10,000	$7,350 / $14,700	$4,000 / $12,000
Preventive Care	Covered in full	Covered in full	Covered in full
Primary Care Visits	0% after deductible	$50 copay	$30 copay
Specialist Visits	0% after deductible	$100 copay	$60 copay
Urgent Care	0% after deductible	$75 copay	$75 copay
Emergency Room	0% after deductible	$500 copay + 30% after deductible	$500 copay + 20% after deductible
Inpatient Hospital	0% after deductible	30% after deductible	20% after deductible
Outpatient Surgery	0% after deductible	30% after deductible	20% after deductible
Labs and X-rays	0% after deductible	30% after deductible	20% after deductible
Advanced Imaging	0% after deductible	30% after deductible	20% after deductible
Out-of-Network Benefits	HSA Plan	Silver Plan	Gold Plan
Annual Deductible Individual / Family	$10,000 / $20,000	$6,000 / $18,000	$2,000 / $6,000
Coinsurance Member Pays	30%	50%	40%
Annual Out-of-Pocket Max Individual / Family	Unlimited	Unlimited	$8,000 / $24,000
Bi-Weekly Payroll Deductions	HSA Plan	Silver Plan	Gold Plan
Employee Only	$0.00	$56.60	$158.89
Employee + Spouse	$258.94	$430.26	$631.27
Employee + Child(ren)	$241.01	$404.37	$598.56
Employee + Family	$499.97	$778.11	$1,071.02

All coverage tiers, except for employee only, have an embedded deductible and OOPM. This means that you will have both an individual and a family deductible and OOPM. No individual will satisfy more than the individual deductible or OOPM.

Refer to the plan documents for full descriptions and details on out-of-network coverage. This chart is intended only to highlight the benefits available and should not be fully relied upon to determine your coverage.

PRESCRIPTION DRUG BENEFITS

When you enroll in a medical plan, you are automatically enrolled in prescription drug coverage. If you regularly take the same medications, a mail-order program may allow you to get a 90-day supply for a lower cost, saving you trips to the pharmacy and time waiting in line. Check with your pharmacy to determine if any special programs are available. Discuss lower-cost alternatives with your physician and check the insurance company's website for a complete drug list at bcbstx.com.

Mail Order Delivery

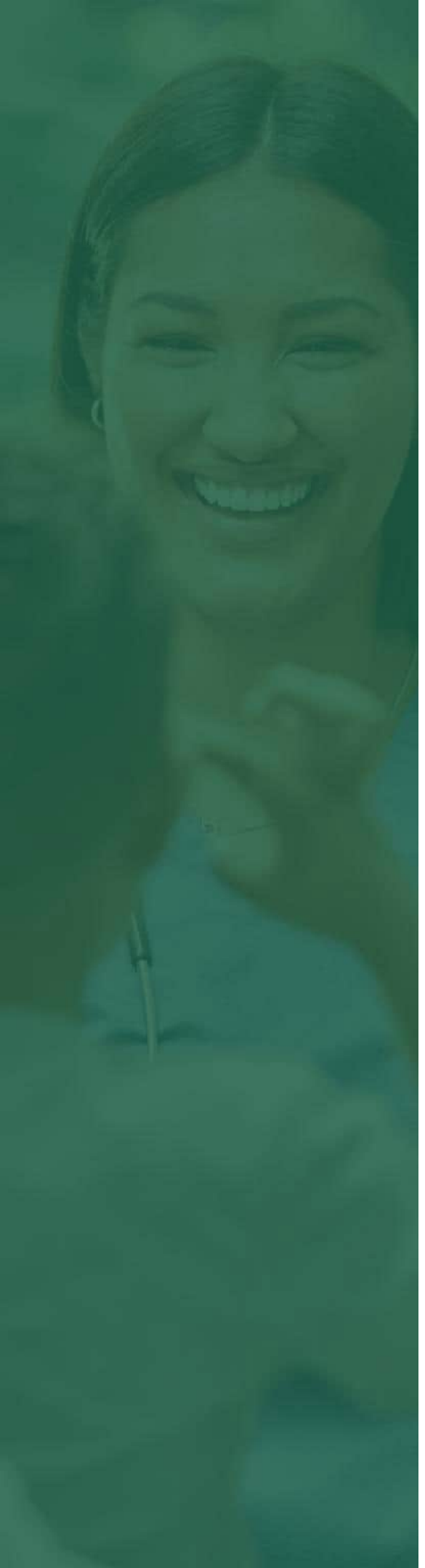
Express Scripts Pharmacy is the home delivery service trusted by Blue Cross and Blue Shield of Texas (BCBSTX) to help lower costs and provide convenience. You can receive up to a 90-day supply of medication at a time which means pharmacy costs may be lower. Visit express-scripts.com/rx to register and create a profile, or call 833-715-0942 to refill, transfer a current prescription, or get started with mail order delivery.

Specialty Medications

BCBSTX supports members who need self-administered specialty medication and helps them manage their therapy. Accredo® is the specialty pharmacy chosen to do just that. You can order a new prescription or transfer your existing prescription for a self-administered specialty drug to Accredo. To start using Accredo, call 833-721-1619. An Accredo representative will work with your doctor on the rest. Once registered, you can manage your prescriptions on accredo.com or through the mobile app.

PLAN HIGHLIGHTS	HSA Plan	Silver Plan	Gold Plan
	In-Network	In-Network	In-Network
Retail Rx Preferred Pharmacy (Up to 30-day supply) • Preferred Generic • Non-Preferred Generic • Preferred Brand • Non-Preferred Brand • Preferred Specialty • Non-Preferred Specialty	No cost after deductible	$0 copay $10 copay $50 copay $100 copay $150 copay $250 copay	$0 copay $10 copay $50 copay $100 copay $150 copay $250 copay
Retail Rx Non-Preferred Pharmacy (Up to 30-day supply) • Preferred Generic • Non-Preferred Generic • Preferred Brand • Non-Preferred Brand • Preferred Specialty • Non-Preferred Specialty	No cost after deductible	$10 copay $20 copay $70 copay $120 copay $150 copay $250 copay	$10 copay $20 copay $70 copay $120 copay $150 copay $250 copay
Mail Order Rx (Up to 90-day supply)	No cost after deductible	3x Preferred Pharmacy copay	3x Preferred Pharmacy copay

Refer to the plan documents for full descriptions and details on out-of-network coverage. This chart is intended only to highlight the benefits available and should not be fully relied upon to determine your coverage.



MEDICAL PLAN RESOURCES

Blue Access for Members℠

Get information about your health benefits, anytime, anywhere. Use your computer, phone or tablet to access the Blue Cross and Blue Shield of Texas (BCBSTX) secure member website, Blue Access for Members (BAM).

With BAM, you can:

- Check the status or history of a claim
- View or print Explanation of Benefits statements
- Locate a doctor or hospital in your plan's network
- Find Spanish-speaking providers
- Request a new ID card or print a temporary one

To get started, visit bcbstx.com/member and click "Register Now." Use the information on your BCBSTX ID card to complete the registration process. Text BCBSTXAPP to 33633 to get the BAM mobile app and access your information anytime, anywhere on the go

Provider Finder

Provider Finder from BlueCross and BlueShield of Texas (BCBSTX) is a fast, easy-to-use tool to find your next health care provider. Plus, it can help you manage health care costs. Go to bcbstx.com and login in or create an account and click on the Doctors and Hospitals tab in Provider Finder to:

- Find Blue Choice in-network providers, hospitals, laboratories and more
- Search by specialty, ZIP code, language spoken, gender and more
- See clinical certifications and recognitions
- Estimate the out-of-pocket costs of more than 1,600 health care procedures, treatments and tests
- Use quality awards such as Blue Distinction® Center (BDC), BDC+ or Total Care to inform your choices
- See side-by-side provider or facility quality ratings and patient reviews

Virtual Visits with MDLive

Virtual Visits: Get Cost-Effective, 24/7 Care

With Virtual Visits powered by MDLIVE®, the doctor is always in. This Blue Cross and Blue Shield of Texas (BCBSTX) benefit gives you access to 24/7 non-emergency care from a board-certified doctor or therapist by phone, online video or mobile app from almost anywhere.

Skip expensive ER bills and waiting to see a doctor. You can speak with a Virtual Visits doctor within minutes.

Services are available in both English and Spanish with translation services available in other languages.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an independent Licensee of the Blue Cross and Blue Shield Association

Powered by MDLIVE

Why Virtual Visits?

- 24/7 access to an independently contracted, board-certified doctor or therapist
- Access via phone, online video or mobile app from almost anywhere
- Average wait time of less than 20 minutes
- Doctors can send e-prescriptions to your local pharmacy

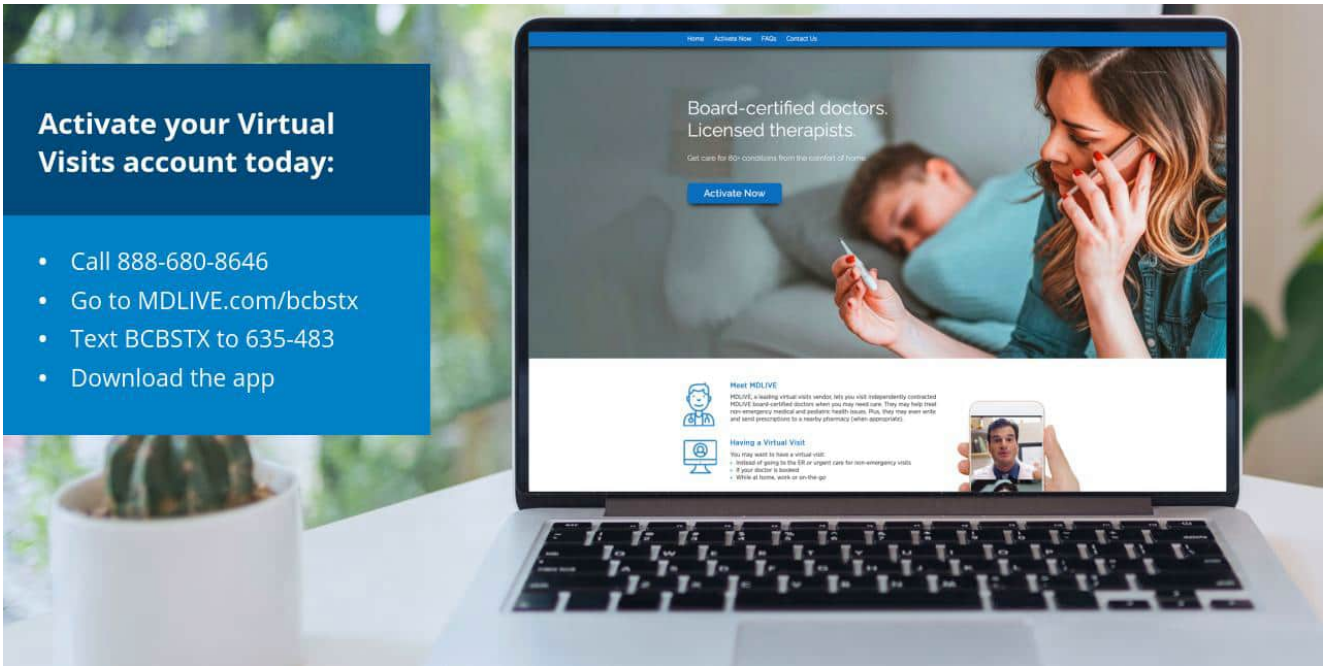
The Virtual Visits benefit is a convenient alternative for treatment of more than 80 health conditions, including:

- Allergies
- Cold/Flu
- Fever
- Headaches
- Nausea
- Sinus infections

Virtual Visits sessions with licensed behavioral health therapists are available by appointment. Get virtual care for:

- Depression
- Eating disorders
- ADHD
- Substance use disorders
- Trauma and PTSD
- Autism spectrum disorder

First, call your doctor's office; they may also offer telehealth consultations by phone or online video. If you have any questions about this or any other BCBSTX benefit, please call the number on the back of your ID card.



WHERE TO GET CARE

The cost for care and the time you wait can vary greatly depending on where you go. Below is a simple guide to selecting the right healthcare provider. In addition to clinical settings, you have access to virtual visits through MDLive.



24/7 Nurseline

If an unexpected medical situation arises, a nurse can help you decide if you should call your doctor, visit the ER or urgent care, or treat the problem yourself. A nurse can also let you know if you can wait to see the doctor the next day.



Doctor's Office

Your primary care physician (PCP) should be your first choice for non-emergency care and ongoing health conditions. Your PCP knows your medical history and can help manage chronic conditions and recommend specialists or other medical care.



Virtual Visit

If your doctor isn't available, you are out of town, or you need care after hours for a simple condition, try a virtual visit. Go online or access the app to schedule an appointment with a physician anytime, 24/7, from anywhere.



Urgent Care and Retail Clinics

If your doctor isn't available, or you need care after hours for a non-life-threatening issue, visit an urgent care or retail health clinic for simple conditions such as a cold or the flu. Urgent care centers can offer a broader range of care, including X-ray services.



Emergency Room

Only visit the ER for serious, life-threatening medical care. If you feel you are dealing with a health emergency, call 911 or go to the ER right away. Do not visit for routine care or minor ailments.

HEALTH SAVINGS ACCOUNTS

When you enroll in a High Deductible Health Plan (HDHP), you are eligible to open a Health Savings Account (HSA) through HSA Bank. This account lets you put pre-tax money aside for qualified healthcare expenses. Because your contributions are deducted pre-tax, you can save up to an estimated 25% on out-of-pocket costs. To participate in an HSA, you must meet the following requirements:

- Be enrolled in a qualified HDHP
- Not be covered by any other non-HSA qualified health plan
- Not be enrolled in Medicare
- Not eligible to be claimed as a dependent on someone else's taxes
- Not enrolled in a standard Healthcare FSA while contributing to your HSA

How It Works

Funds are automatically deducted from your paycheck and deposited into your account. Unused funds carry over from year to year and can build over time. And HSAs are portable; if you leave 4-Horn Investments, you can take the account. In addition to your contributions, 4-Horn Investments will make the following annual contribution:

- Individual coverage: $650
- Employee + one or more family members coverage: $1,950

** New hires will receive a prorated contribution for the period the are eligible.*

Contribution Limits

The IRS sets the annual contribution levels for HSAs. It is your responsibility to monitor the amounts deposited into your account not to exceed the maximum limit, keeping in mind that any funds contributed by 4-Horn Investments also count towards the maximum amount.

The 2027 IRS contribution limits are:

- Individual coverage: $4,500
- Family coverage: $9,000
- Eligible individuals aged 55 and older may contribute an additional $1,000 annually.

Eligible Expenses

Use your HSA funds to pay for healthcare items such as copays, prescriptions, home care, medical supplies and equipment, and other out-of-pocket expenses your insurance may not cover.

You may also use these funds for dental and vision expenses, counseling, chiropractic care, physical therapy, certain OTC medications, and more. Visit irs.gov/forms-pubs/about- publication-502 to see a complete list of IRS-qualified expenses.

Coverage Level	IRS Maximum	4-Horn Contribution	Employee Max Contribution
Single	$4,500	$650	$3,850
Family	$9,000	$1,950	$7,050

HEALTH REIMBURSEMENT ACCOUNT

For members enrolled in Silver Plan, 4-Horn helps pay for health care expenses by contributing to a Health Reimbursement Arrangement (HRA). An HRA is an employer-funded arrangement that reimburses you for certain medical expenses. HRAs are meant to help you be more aware of your health care costs while also helping you meet your deductible with tax-free funds. HRAs can be a great way to pay for out-of-pocket health care expenses while still working down your deductible. For eligible employees, (those enrolled in Silver Plan) 4-Horn will contribute $25 bi-weekly to the HRA. If you are enrolled in employee plus dependent coverage, 4-Horn will contribute $50 bi-weekly to the HRA.

General Information

- There is no cost to employees for participation in the HRA.
- Unused HRA benefits do not roll over to subsequent plan years and may not be cashed out or used for any reason other than the reimbursement of eligible expenses.
- Unused HRA benefits do not roll over to subsequent plan years and may not be cashed out or used for any other reason other than the reimbursement of eligible expenses.
- Expenses that are reimbursed or are reimbursable from any other benefit plan (except for Medicare or TriCare) are not eligible expenses for reimbursement under the HRA.
- All reimbursements are sent directly to the employee; it is the employee's responsibility to pay the medical provider.
- Below is an example of how the HRA could help someone enrolled in employee only coverage should they require a $10,000 surgery. This example assumes no previous insurance claims

Silver Plan	Amount	Notes
Employee Only Deductible	$3,000	The amount the employee is responsible for before the plan pays
Total Claims (hospital stay)	$10,000	Final bill by the in-network hospital to the insurance company after in-network discounts are applied
4-Horn Pays via HRA	$650	4-Horn contributes up to $650 to the HRA for individuals annually
Employee Pays	$2,350	The deductible is now met, and the plan starts to pay
Remaining Claims Balance	$7,000	The maximum out-of-pocket is $7,350. The insurance company is responsible for any amount over $7,350.
Coinsurance (employee pays 30% of remaining $7,000 after meeting deductible)	$2,100	After the deductible is met, the employee pays 30% of any remaining claims. The insurance company pays 70%.
Total Employee Amount Paid	$4,450	Of the $10,000 in billed services, the employee is responsible for $4,450, 4-Horn contributed $650, and the plan paid $4,900.

FLEXIBLE SPENDING ACCOUNTS

4-Horn Investments offers Flexible Spending Accounts (FSAs) through WEX. FSAs help you pay for eligible medical, dental, vision, and dependent care out-of-pocket costs by allowing you to set aside pre-tax contributions. Health care funds are available to use as of January 1st, even money you have not contributed yet. Dependent care funds are only available as you contribute.

Employees enrolled in the HSA medical plan may only participate in a Limited Purpose Health Care FSA, which means funds can only be used for qualified dental and vision expenses, not medical. All employees are eligible for a Dependent Care FSA.

How It Works

Determine the amount you wish to have deducted from each paycheck, and the funds are automatically deposited to your account(s). You may only use Health Care FSA money for health care expenses and Dependent Care FSA for funds for dependent care expenses. You must re-enroll each year to continue funding the account(s), and you can incur expenses only during the plan year you are enrolled. All unused Health Care and Dependent Care funds will be forfeited, so estimate wisely.

Contribution Limits

You are responsible for monitoring the amounts deposited into your accounts not to exceed the maximum annual limits.

The 2027 FSA contribution limits are as follows:

- Health Care FSA: **$3,500***
- Dependent Care FSA: $7,500 per household ($3,750 if married, filing separately)

Eligible Expenses

Use your Health Care FSA funds to pay for out-of-pocket medical, dental, hearing, and vision expenses such as copays, prescriptions, supplies, appliances, and some OTC items. Visit irs.gov/forms-pubs/about-publication-502 to see a complete list of IRS-qualified health care expenses.

Use Dependent Care FSA funds to pay for qualified daycare expenses for children aged 12 and younger or an adult-dependent incapable of self-care. Eligible expenses include daycare, preschool, elder care, and in-home aids. Visit irs.gov/publications/p503 to see a complete list of IRS-qualified dependent care expenses.

***Projected 2027 limit** – subject to final IRS guidance

DENTAL BENEFITS

4-Horn Investments offers dental coverage through BCBS of TX. These plans allow you to use in-network or out-of-network benefits. However, you will be responsible for paying the difference between the allowed amount and what the dentist may charge, also known as "balance billing," when you visit an out- of-network provider. To find an in-network provider, go to bcbstx.com/find-care/find-a-dentist. The chart below provides a brief overview of the plan. Refer to the full plan description for detailed coverage information and out-of-network benefits.

PLAN HIGHLIGHTS	PPO Plan (MAC)	PPO Plan (90th)
	In-Network	In-Network
Calendar Year Deductible	$50 individual/$150 family max	$50 individual/$150 family max
Annual Plan Maximum	$1,500 per member	$1,500 per member
Preventive Services Exams, fluoride, x-rays	Covered in full	Covered in full
Basic Services Simple extractions, fillings, periodontics, endodontics	Plan pays 100% after deductible	Plan pays 80% after deductible
Major Services Crowns, bridges, dentures	Plan pays 60% after deductible	Plan pays 50% after deductible
Orthodontics Children to age 19 only	Plan pays 50% of billed charges up to a maximum of $1,500	Plan pays 50% of billed charges up to a maximum of $1,500
Out-of-Network Reimbursement	MAC	UCR – 90th percentile
Bi-Weekly Payroll Deductions	MAC/PPO Plan	
Employee Only	$0.00	
Employee + Spouse	$13.34	
Employee + Child(ren)	$21.20	
Employee + Family	$39.19	

Late Entrants: A late entrant limitation of 12 months for all Orthodontia Services will apply to employees who enroll in this dental plan more than 30 days after becoming eligible.

Balance Billing: The amount the plan pays for a covered procedure based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network dentist charges $500 for a procedure and the out-of-network reimbursement is $200, you may have to pay the $300 difference in addition to your out-of-network coinsurance and/or deductible.

VISION BENEFITS

4-Horn Investments offers vision coverage through BCBS of TX on the EyeMed Vision Care Network. The vision plan allows you to use in-network or out-of-network providers. However, when using out-of-network providers, you will pay expenses at the time of service and file a claim for reimbursement.

To find in-network providers visit eyemed.com and enter your search criteria. The chart below provides a brief overview of the plan. Refer to the full plan description for detailed coverage information.

PLAN HIGHLIGHTS	Vision Plan	
	In-Network	Out-of-Network Reimbursement
Eye Exam	$10 copay	Up to $30
Materials Copay	$25 copay	N/A
Lenses • Single Vision • Lined Bifocal • Lined Trifocal • Lenticular	$25 copay	 Up to $25 Up to $40 Up to $55 Up to $55
Frames	$130 allowance + 20% off balance	Up to $65
Contact Lenses* • Elective • Medically Necessary	$130 allowance + 20% off balance Covered in full	 Up to $104 Up to $210
Frequencies • Eye Exam • Lenses • Frames	Once every 12 months Once every 12 months Once every 24 months	
Bi-Weekly Payroll Deductions	Vision Plan	
Employee Only	$0.00	
Employee + Spouse	$2.82	
Employee + Child(ren)	$3.13	
Employee + Family	$6.08	

**Contact lenses benefit is in lieu of eyeglass frames and lens benefit.*

Refer to the plan documents for full descriptions and details on out-of-network coverage. This chart is intended only to highlight the benefits available and should not be fully relied upon to determine your coverage.

LIFE AND AD&D INSURANCE

Basic Life and Accidental Death & Dismemberment (AD&D)

4-Horn Investments provides each employee with Basic Life and Accidental Death & Dismemberment insurance through Symetra and pays for the full cost of coverage. Eligible employees receive $30,000 in coverage. Ensuring your beneficiary information is correct at enrollment and throughout the year is essential. Log in to ADP or contact HR to update your beneficiary information anytime. Age reduction schedule: 35% at age 65, 50% at age 70

Voluntary Life and AD&D Insurance

4-Horn Investments employees can supplement their company-paid Basic Life insurance by purchasing additional coverage through Symetra. In addition, you may purchase coverage for a spouse and child(ren) after electing coverage for yourself.

The Guarantee Issue (GI) amount is the highest amount of coverage that you or your dependents may elect without completing an Evidence of Insurability (EOI) form. If you elect an amount above the GI limit or wish to increase your benefit amount at a future date, the coverage amount over the GI level will not go into effect until your EOI has been reviewed and approved and payroll deductions have begun. For full details, refer to the Certificate of Coverage.

You may purchase the following amounts for yourself and your dependents. Refer to ADP to calculate your coverage cost.

Employee	Spouse	Child(ren)
Increments of $10,000 up to 7x annual earnings amount to $500,000 maximum.	Increments of $5,000 up to $200,000 not to exceed 50% of employee amount.	Flat amount: $10,000
Guarantee Issue: $250,000	Guarantee Issue: $50,000	Guarantee Issue: $10,000



DISABILITY INSURANCE

Whether you are disabled and unable to work due to an accident or illness, 4-Horn Investments offers both Short- and Long-Term Disability options through Symetra. Disability is insurance for your paycheck should you become disabled due to an off-the-job injury or illness. This coverage will provide a percentage of your salary once you satisfy the waiting period. Refer to the Plan Summaries for details.

Voluntary Short-Term Disability

4-Horn Investments offers employees the option to purchase Short-Term disability (STD) insurance. After a 7-day waiting period, the benefit would pay 60% of your weekly pre-disability earnings to a maximum of $2,500 per week up to 12 weeks or until you no longer meet the definition of disability, whichever occurs first.

Employer-Paid Long-Term Disability

4-Horn Investments offers Long-Term disability (LTD) and pays the full cost of coverage. After a 90-day waiting period, the benefit would pay 60% of your monthly pre-disability earnings to a maximum of $10,000 per month until you no longer meet the definition of disability or reach the Social Security Normal Retirement Age (SSNRA).

Your cost for coverage can be calculated on ADP when you make your benefit elections.

WORKSITE BENEFITS
VOLUNTARY ACCIDENT

4-Horn Investments offers employees the option to purchase supplemental worksite benefits voluntarily provided through Symetra. In addition, you have the option to cover your spouse and child(ren) after electing coverage for yourself. The premiums for elected benefits are deducted from your paycheck. The Accident plan also offers a **$125 health screening benefit.**

Voluntary Accident

Where most medical plans only pay a portion of the bills, Accident insurance can help pick up where other insurance leaves off. This policy provides a cash benefit to cover expenses if you or a covered dependent experience an eligible event. Listed below is only a partial list visit 4hornemployeebenefits.com for more details.

PLAN HIGHLIGHTS	
	EMERGENCY BENEFITS
Emergency Room per accident	$300
Initial Physician's visit per accident	$300
Ambulance Benefit Ground / Air	$300 / $1,500
	HOSPITALIZATION BENEFITS
Hospital Admission / ICU Admission	$2,000 / $4,000 per accident
Hospital Confinement / ICU Confinement	$800 daily / $1,600 daily (up to 30 days per accident)
Rehabilitation Unit per day	$150 per day up to 90 days per accident
	SPECIFIC INJURIES
Coma	$15,000
Concussion	$200
Fractures	Up to $3,000
Dislocations	Up to $3,000
Lacerations	Up to $600
Burns	$100 - $15,000
WELLNESS BENEFIT	**$125 PER COVERED PERSON**

Bi-Weekly Payroll Deductions	Accident Plan
Employee Only	$6.84
Employee + Spouse	$11.22
Employee + Child(ren)	$13.41
Employee + Family	$20.93

WORKSITE BENEFITS
VOLUNTARY CRITICAL ILLNESS

4-Horn Investments offers employees the option to purchase supplemental worksite benefits voluntarily provided through Symetra. In addition, you have the option to cover your spouse and child(ren) after electing coverage for yourself. The premiums for elected benefits are deducted from your paycheck. The Critical Illness plan also offers a **$125 health screening benefit.**

Voluntary Critical Illness

Critical Illness insurance pays a lump sum cash benefit when you or a covered family member is diagnosed with a serious illness, such as a heart attack, stroke, major organ failure, or cancer. You may use this benefit in any way you choose to pay for expenses that are not medical but have occurred due to the diagnosis, such as lost wages, family care, rehabilitation, or transportation. Benefits are paid to you regardless of any additional coverage you may have. Listed below is only a partial list visit 4hornemployeebenefits.com for more details.

PLAN HIGHLIGHTS	CRITICAL ILLNESS WITH CANCER
Initial Diagnosis	$10,000, $20,000, $30,000 or $40,000
Maximum Guarantee Issue	All GI (EE + SP)
Heart Attack	100%
Sudden Cardiac Arrest	100%
Stroke	100%
Major Organ Failure	100%
Coronary Artery Disease requiring surgery or Angioplasty	50%
End Stage Renal Failure	100%
Invasive Cancer	100%
Minor Cancer	50%
Skin Cancer	$500
Permanent Paralysis	100%
Coma	100%
Benign Brain Tumor	100%
Advanced Alzheimer's Disease	100%
ALS (Lou Gehrig's Disease)	100%
Parkinson's Disease	100%
Advanced Multiple Sclerosis	100%
Severe Burns	100%
Dementia	100%
WELLNESS BENEFIT	**$125 PER COVERED PERSON**

WORKSITE BENEFITS
VOLUNTARY HOSPITAL INDEMNITY

4-Horn Investments offers employees the option to purchase supplemental worksite benefits voluntarily provided through Symetra. In addition, you have the option to cover your spouse and child(ren) after electing coverage for yourself. The premiums for elected benefits are deducted from your paycheck. The Hospital Indemnity plan also offers a **$125 health screening benefit.**

Voluntary Hospital Indemnity

Critical Illness insurance pays a lump sum cash benefit when you or a covered family member is diagnosed with a serious illness, such as a heart attack, stroke, major organ failure, or cancer. You may use this benefit in any way you choose to pay for expenses that are not medical but have occurred due to the diagnosis, such as lost wages, family care, rehabilitation, or transportation. Benefits are paid to you regardless of any additional coverage you may have. Listed below is only a partial list visit 4hornemployeebenefits.com for more details.

PLAN HIGHLIGHTS	INPATIENT HOSPITAL BENEFITS
	500 DAYS LIFETIME MAXIMUM
Initial Hospital Admission (following 24-hour inpatient confinement)	$1,250
Daily Benefit for Hospital Confinement (day 2+)	$250 per day 365 incidents per person, per policy
Initial Hospital Admission ICU (following 24-hour inpatient confinement)	$1,250
Daily Benefit for Hospital Confinement ICU (day 2+)	$500 per day 30 incidents per person, per policy
Substance Abuse, Mental Health or Nursing Facility	$100 per day days per person, per policy
	POLICY PROVISIONS
Benefit Waiting Period	None
Pregnancy Limitation Period	None
Age - Based Benefit Reduction	None
Pre-Existing Condition Limitation	None
Termination Age	None
Portability / Continuation	Included
WELLNESS BENEFIT	$125 PER COVERED PERSON

Bi-Weekly Payroll Deductions	Hospital Plan
Employee Only	$12.60
Employee + Spouse	$26.84
Employee + Child(ren)	$20.64
Employee + Family	$37.37

WELLNESS PROGRAM

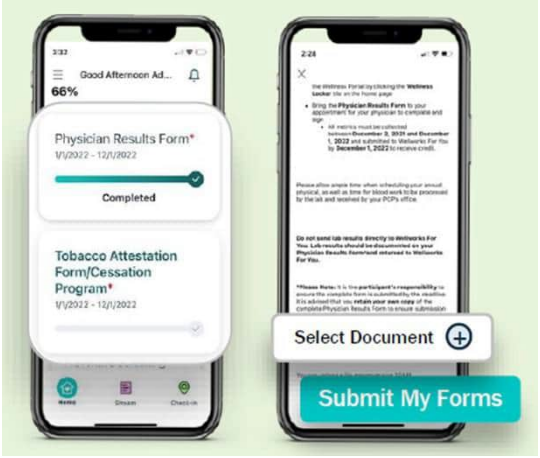
Employees participating in the 4-Horn Wellness Program will save $650 annually in medical premiums and will also earn two hours of sick time. Non-participating employees will have higher costs for 2027.

New hires hired after July 1, 2027, will automatically receive the premium differential for the remainder of 2027. To retain this premium differential going forward, you will need to participate in the 4-Horn Wellness Program.

Take these steps toward improving your health and receive discounted medical premiums:

1. See your Primary Care Physician between November 1, 2026, and October 31, 2027.
2. Have your doctor complete the well visit and age / gender- appropriate related preventive testing
3. Keep record of this visit for verification
4. Follow the steps in your WellWorks wellness guide to access the app or portal with your own login. Upload your physician documented results via the mobile app or web portal.

Contact the Wellness Team with any questions.



TERMS TO KNOW

Deductible: The amount an employee pays out of pocket before the insurance company pays a percentage of the provider charges.

Coinsurance: The amount of payment split between the employee and the insurance company. Example: The insurance company pays 80%, and the employee pays 20% of the charges after you meet the deductible.

Out-of-Pocket Maximum: The maximum amount an employee is responsible for paying out of pocket in any calendar year before the insurance company pays the entire eligible amount for the remaining calendar year.

Network Providers: Doctors, hospitals, and other healthcare providers with an agreement/ contract with insurance companies agreeing to charge a discounted amount for services rendered.

Pre-Authorization: Certain procedures or hospitalizations may require that the provider receive authorization. The provider is typically the one to go through this process with the insurance company and obtain pre-authorization.

Explanation of Benefits (EOB): The EOB is mailed to the employee after the insurance company receives and processes a claim. The EOB describes how the claim was processed and outlines what portion of the charges have been applied to the deductible, what amount the employee is responsible for, and explains if there was a denial or error in processing the claim.

Appeal: If your health insurance company doesn't pay for a specific health care provider or service, you have the right to appeal the decision and have it reviewed by an independent third party.

Guarantee Issue: The maximum amount of voluntary life insurance you can choose when making your initial election that does not require the answering of medical questions.

Evidence of Insurability (EOI): The form containing medical questions you must answer if you decide to elect voluntary life insurance after you have previously declined coverage and wish to increase your current coverage later. The form may also be required if you add disability coverage after previously declined.

IMPORTANT NOTICES

A printed copy of the full versions of the below notices along with the plan summaries can be obtained below using the QR Codes below:

HIPAA PRIVACY AND SECURITY – NOTICE OF PRIVACY PRACTICES

HHS regulations require that participants be provided with a detailed explanation of their privacy rights, the plan's legal duties with respect to protected health information, the plan's uses and disclosures of protected health information, and how to obtain a copy of the Notice of Privacy Practices.

HIPAA PORTABILITY – NOTICE OF SPECIAL ENROLLMENT RIGHTS

This notice describes a group health plan's special enrollment rules including the right to special enroll within 30 days of the loss of other coverage or of marriage, birth of a child, adoption, or placement of a child for adoption, or within 60 days of a determination of eligibility for a premium assistance subsidy under Medicaid or CHIP.

COBRA – FIRST NOTICE OF COBRA RIGHTS

This notice advises covered employees, covered spouses, and covered dependents of the right to purchase a temporary extension of group health coverage when coverage is lost due to a qualifying event.

PRESCRIPTION DRUG COVERAGE AND MEDICARE

Entities that offer prescription drug coverage on a group basis to active and retired employees and to Medicare Part D eligible individuals – must provide, or arrange to provide, a notice of creditable or non-creditable prescription drug coverage to Medicare Part D eligible individuals who are covered by, or who apply for, prescription drug coverage under the entity's plan. This creditable coverage notice alerts the individuals as to whether or not their prescription drug coverage is at least as good as the Medicare Part D coverage.

MEDICAL PRE-TAX PREMIUMS PLAN

Enrollment in a pre-tax premium plan authorizes premiums for group health plan benefits to be payroll deducted on a pre-tax basis.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT NOTICE (CHIPRA)

This annual notice notifies employees of potential state opportunities for premium assistance to help pay for employer- sponsored health coverage.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE (WHCRA)

Participants and beneficiaries of group health plans who are receiving mastectomy-related benefits can choose to have breast reconstruction following a mastectomy.

HEALTH CARE REFORM NOTICE: NOTICE OF EXCHANGE/ MARKETPLACE

Employer must provide all employees with an Exchange Notice that includes a description of services provided by the Exchange. The notice must explain the premium tax credit available if a qualified health plan is purchased through the Exchange. The employee must also be informed that they may lose the employer contribution to any benefit plans offered by the employer if a health plan through the Exchange is elected.

WELLNESS PROGRAM DISCLOSURE

If it is unreasonably difficult due to a medical condition for you to achieve the standard for reward or if it is medically inadvisable for you to attempt to achieve the standard for reward under your employer's wellness program, please contact your employer's Human Resources representative to develop another way for you to qualify for the wellness program reward.

YOUR RIGHTS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out- of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

Participant Notice:

Chip Notice:



The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by your employer. The text contained in this Summary was taken from various summary plan descriptions and benefits information. While every effort was taken to report your benefits, discrepancies or errors are always possible. In case of a discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this Summary, contact Human Resources.

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