SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #9
TO THE
VILLA RESTAURANT GROUP
EMPLOYEE BENEFIT PLAN – PREMIUM PLAN
GROUP NO. 16909

This Summary of Material Modification and Amendment describes changes to the Villa Restaurant Group Employee Benefit Plan - Premium Plan effective July 1, 2019. These changes are effective as of **January 1, 2025** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

Villa Enterprises Management LTD, Inc. (the "Plan Sponsor") is amending the Villa Restaurant Group Employee Benefit Plan - Premium Plan (the "Plan") as follows:

1. *The **Medical Schedule of Benefits** and the **Prescription Drug Schedule of Benefits** are hereby deleted and replaced as shown in **Exhibit A** and **Exhibit B**.*

2. *The **Surrogate** exclusion under **General Exclusions and Limitations** is hereby deleted and replaced with the following:*

GENERAL EXCLUSIONS AND LIMITATIONS

Surrogate: Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan will not be considered eligible, including but not limited to pre-pregnancy, conception, prenatal, childbirth and postnatal expenses.

3. *The **Gambling Addiction** exclusion under **General Exclusions and Limitations** is hereby deleted and not replaced.*

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, Villa Restaurant Group has caused this Amendment to take effect, be attached to, and form a part of their Employee Benefit Plan - Premium Plan.

_____ _____

Authorized Signature Date Title

_____ _____

Witness Date Title

EXHIBIT A

MEDICAL SCHEDULE OF BENEFITS

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Single	$1,500	$3,000
Family	$3,000	$6,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)		
Single	$6,250	$11,500
Family*	$12,500	$23,000
MEDICAL BENEFITS		
Ambulance Services	80% after Deductible	Paid at Participating Provider level of benefits
Cardiac Rehab (Outpatient)	$40 Copay, then 100% Deductible waived	60% after Deductible
Chemotherapy (Outpatient)	80% after Deductible	60% after Deductible
Chiropractic Care/Spinal Manipulation	$40 Copay, then 100% Deductible waived	60% after Deductible
Cognitive Rehabilitation Therapy	$40 Copay, then 100% Deductible waived	60% after Deductible
Congenital Heart Disease Surgeries	80% after Deductible	60% after Deductible
Dental Care – Accident Only*	80% after Deductible	Paid at Participating Provider level of benefits
* Please refer to the Dental Care Benefit section for a more detailed description of this benefit.		
Diabetic Education	Paid based on place of service	Paid based on place of service
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	80% after Deductible	60% after Deductible
Dialysis (Outpatient)	80% after Deductible	60% after Deductible
Durable Medical Equipment (DME)	80% after Deductible	60% after Deductible
Maximum Benefit Per 3-Year Period*	Single purchase (including repair/replacement) per type of DME	
*Limit does not apply to wound vacuums.		
Emergency Services/Emergency Room Services	$200 Copay, then 100% Deductible waived	Paid at the Participating Provider level of benefits
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.		
Gender Dysphoria	Paid based on place of service	Paid based on place of service

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hearing Aids and Related Supplies	80% Deductible waived	60% after Deductible
Maximum Benefit Per 24-Month Period for Covered Persons up to age 16	One hearing aid per hearing impaired ear	
Maximum Benefit Per 24-Month Period for Covered Persons age 16 and over	$2,500 per hearing impaired ear	
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Hearing Examination	100% Deductible waived	60% after Deductible
Calendar Year Maximum Benefit	1 exam	
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Hemophilia Services	80% after Deductible	60% after Deductible
Home Health Care	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit*	60 visits	
*This visit limit does not include any service which is billed only for the administration of intravenous infusion.		
Hospice Care	80% after Deductible	60% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	80% after Deductible	60% after Deductible
Room and Board Allowance*	*Semi-Private Room Rate	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	80% after Deductible	60% after Deductible
Newborn Care**	80% Deductible waived	60% Deductible waived
Outpatient	80% after Deductible	60% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room. **Deductible will not apply only if the length of stay in the Hospital is the same as the mother's length of stay.		
Infertility	80% after Deductible	60% after Deductible
Lifetime Maximum Benefit	4 completed egg retrievals and the procedures and treatments associated with such retrieval	
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Infusion Therapy (Outpatient)	80% after Deductible	60% after Deductible
Maternity (Professional Fees)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100% Deductible waived	60% after Deductible
Lactation Consultations	100% Deductible waived	100% Deductible waived
Initial Office Visit	$30 Copay, then 100% Deductible waived	
All Other Prenatal and Postnatal Care	100% Deductible waived	60% after Deductible
Delivery	80% after Deductible	60% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Mental Disorders and Substance Use Disorders		
Inpatient	80% after Deductible	60% after Deductible
Outpatient (includes Telemedicine)	$30 Copay, then 100% Deductible waived	60% after Deductible
Partial Hospitalization/Intensive Outpatient Treatment	80% after Deductible	60% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
MinuteClinic	100% Deductible waived	Not Applicable
Occupational Therapy (OT) (Outpatient)	$40 Copay, then 100% Deductible waived	60% after Deductible
Orthotics	80% after Deductible	60% after Deductible
Physical Therapy (PT) (Outpatient)	$40 Copay, then 100% Deductible waived	60% after Deductible
Physician's Services		
Inpatient/Outpatient Services	80% after Deductible	60% after Deductible
Office Visits/Telemedicine:		
Primary Care Physician	$30 Copay, then 100% Deductible waived	60% after Deductible
Specialist	$40 Copay, then 100% Deductible waived	60% after Deductible
Physician Office Surgery	80% after Deductible	60% after Deductible
Teladoc	$15 Copay, then 100% Deductible waived	N/A
*Copay applies to the Physician office visit component and laboratory services only. All other services are paid subject to any Deductible and Coinsurance percentages.		
Post-Cochlear Implant Aural Therapy (Outpatient)	$40 Copay, then 100% Deductible waived	60% after Deductible
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item received at the same time as the preventive service, whether billed at the same time or separately)	100% Deductible waived	60% after Deductible
Routine Care (includes any routine care item or service not otherwise covered under the preventive service provision above)	100% Deductible waived	60% after Deductible
Prosthetics	80% after Deductible	60% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Pulmonary Therapy (Outpatient)	$40 Copay, then 100% Deductible waived	60% after Deductible
Reconstructive Surgery	Paid based on place of service	Paid based on place of service
Scopic Procedures (Outpatient Diagnostic and Therapeutic)	80% after Deductible	60% after Deductible
Skilled Nursing Facility and Rehabilitation Facility	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit*	60 days	
*Calendar Year Maximum Benefit limit is combined with therapies associated with developmental delays. Limit does not apply to the treatment of autism spectrum disorder.		
Speech Therapy (ST) (Outpatient)	$40 Copay, then 100% Deductible waived	60% after Deductible
Surgery (Facility, Miscellaneous and Professional fees) (Outpatient) (does not include Surgery in the Physician's office)	80% after Deductible	60% after Deductible
Transplants	80% after Deductible (Aetna IOE Program)* Not Covered (All Other Network Providers)	60% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit. Travel and lodging will be paid at 100% after Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
Urgent Care Facility	$55 Copay*, then 100% Deductible waived	60% after Deductible
*Copay applies to the Physician office visit component and laboratory services only. All other services are paid subject to any Deductible and Coinsurance percentages.		
All Other Eligible Medical Expenses	80% after Deductible	60% after Deductible

EXHIBIT B

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – PREMIUM PLAN

BENEFIT DESCRIPTION	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Copays – combined with major medical Out-of-Pocket)		
Single	$6,250	
Family	$12,500	
Retail Pharmacy: 30-day supply		
Generic Drug	$5 Copay	$35 Copay
Preferred Drug	$35 Copay	$70 Copay
Non-Preferred Drug	$70 Copay	$105 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)	
Specialty Pharmacy Program: 30-day supply		
Specialty Drug	20% Copay	Not Covered
NOTE: Specialty Drugs MUST be obtained directly from the specialty pharmacy. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.		
Retail Pharmacy: 90-day supply (Maintenance Medication Only)		
Generic Drug	$12.50 Copay	$42.50 Copay
Preferred Drug	$87.50 Copay	$175 Copay
Non-Preferred Drug	$175 Copay	$262.50 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)	
Mail Order Pharmacy: 90-day supply		
Generic Drug	$12.50 Copay	Not Covered
Preferred Drug	$87.50 Copay	Not Covered
Non-Preferred Drug	$175 Copay	Not Covered
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)	

Specialty Pharmacy Program
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.