INFRAMARK, LLC
FLEXIBLE BENEFITS PLAN

January, 2023

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Table of Contents

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WHEREAS, Inframark, LLC ("Inframark" or the "Employer"), maintains the Inframark, LLC Flexible Benefits Plan (the "Section 125 Plan" or the "Flex Plan"), that was assumed in a corporate transaction that occurred in or about 2017; and

WHEREAS, the Flex Plan was amended by an Amendment, as attached hereto, to make various "Good Faith" Amendments to comply with the Consolidated Appropriations Act of 2021 ("CAA"); the American Rescue Plan Act of 2021 ("ARP"); IRS Notices 2021-15 and 2021-26; Announcement 2021-7; IRS Notice 2020-3; the Employee Benefits Security Administration ("EBSA") Disaster Relief Notices 2020-01 and 2021-01 to deal with the COVID-19 pandemic; and

WHEREAS, the pandemic relief has expired and need not be included in the Flex Plan; and

WHEREAS, Inframark wishes to amend and restate the Flex Plan effective as of January 1, 2023, to ensure that the current Flex Plan document is consistent with all administrative policies and procedures; and

WHEREAS, a separate Inframark Dependent Care Assistance Plan (the "Dependent Care Plan") exists, as also amended and restated effective as of January 1, 2023; and

WHEREAS, the Dependent Care Plan shall remain in effect, and shall continue to be integrated with the Flex Plan; and

WHEREAS, Inframark is aware that the Section 125 Regulations have not been finalized and may not be finalized for several years; and

WHEREAS, Inframark , nevertheless, wishes to amend and restate the Flex Plan.

NOW, THEREFORE, effective as of January 1, 2023, except as indicated elsewhere, the Flex Plan is amended and restated for the exclusive benefit of the employees of Inframark and any Participating Employers, as set forth below:

ARTICLE I
PURPOSE OF THE PLAN

1.1 **Purpose**. This Plan is a "cafeteria plan" established for the purpose of furnishing Eligible Employees of the Employer, and any Participating Employers, with the option of receiving one or more Nontaxable Benefits in lieu of receiving taxable compensation paid in cash. It is intended that this Plan satisfy the requirements of Section 125 of the Code, and that the benefits which an Eligible Employee elects to receive under the Plan, to the extent such benefits are Nontaxable Benefits, be eligible for exclusion from the Employee's income under Section 125(a) of the Code. Nontaxable Benefits paid under the Plan shall also be exempt from Social Security and Federal Unemployment Taxes and, where permissible, state and local taxation. In no event, however, shall any benefits be paid under the Plan in any manner which might defer the receipt of Compensation beyond the last day of any Plan Year.

ARTICLE II
DEFINITIONS

2.1 **"Administrator"** means the Employer, unless the administration of the Plan is delegated to any individual or individuals, Committee or Third-Party Administrator appointed by the Board to administer the Plan.

2.2 **"Appropriate Form"** means the form prescribed or provided by the Administrator for a particular purpose.

2.3 **"Benefit Package Option"** means a qualified benefit under Section 125(f) of the Code that is offered under the Flex Plan, or an option for coverage under an underlying health plan (such as an indemnity option, an HMO option, or a PPO option under any health plan).

2.4 **"Board"** means the Board of Directors of Inframark.

2.5 **"Civil Union Partner"** means a person of the same-sex or opposite-sex as a Participant, as permitted under state law. A Civil Union Partner shall generally be treated as a Domestic Partner for all provisions of the Plan.

2.6 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time.

2.7 **"Compensation"** means all basic compensation received from the Employer during the Plan Year without regard to any salary reduction under this Plan excluding, however, over-time pay and bonuses.

2.8 **"Dental Plan"** means the insured or self-insured dental plan or plans maintained by the Employer or any Participating Employer, attached as an **Exhibit** hereto, and incorporated into this Plan by reference.

2.9 **"Dental Premium Contribution Account"** means the account established for the purpose of paying the cost for Eligible Employees to receive benefits under the Dental Plan.

2.10 **"Dependent"** means (i) a dependent as defined in Section 152 of the Code with respect to whom the Participant or his or her Eligible Domestic Partner is entitled to a deduction under Section 151 of the Code; (ii) any individual who is eligible for coverage under a Health Benefit pursuant to a Qualified Medical Child Support Order; and (iii) an Eligible Domestic or Civil Union Partner. For purposes of accident or health coverage, a dependent of a custodial parent, under Section 152(e) of the Code, shall be treated as a dependent of both parents and, for purposes of any Dependent Care Plan, a dependent means a qualifying individual under Section 21(b)(1) of the Code (i.e., under the age of **13**, or a dependent or spouse who is physically unable to care for himself). This definition is intended to comply with all tax rules, as they may change from time to time under the Code. The definitions for a "Child" and for a "Dependent" for

purposes of the Flex Plan shall be automatically amended to be consistent with all underlying Health Plans, as identified as **Exhibits** to the Flex Plan, provided, however, that such definition shall include a Child as defined in Section 152(f)(1) of the Code who has not attained age **27** by the end of any calendar year.

2.11 **"Dependent Care Assistance Plan"** means the Inframark, LLC Dependent Care Assistance Plan, as amended from time to time and attached as an **Exhibit**. The terms of the Dependent Care Assistance Plan are incorporated into this Plan by reference herein.

2.12 **"Dependent Care Reimbursement Account"** means the Account established within the records of the Plan for each Participant who elects dependent care coverage under any Dependent Care Assistance Plan, as integrated into this Plan.

2.13 **"Disability Coverage"** means coverage under an accident or health plan that provides benefits due to personal injury or sickness, but does not reimburse expenses for medical care for a participant, or the participant's spouse or dependents.

2.14 **"Domestic Partner"** means a person of the same or opposite sex as the Employee who has a single, dedicated relationship with the Employee that contains the following elements:

(a) Both the Employee and Domestic Partner are at least **18** years of age and mentally competent to consent to contract.

(b) The relationship is intended to last indefinitely.

(c) The Employee and Domestic Partner:

(i) Share the same permanent residence and have done so for at least **6** to **12** months, as determined by the Plan Administrator;

(ii) Are not related by blood to a degree of closeness which would prohibit marriage under the laws of the state in which they reside;

(iii) Are not married (to anyone) under either any state statutes or common law; and

(iv) Are financially interdependent. To prove this element, the Employee must provide the Employer with at least **2** of the following documents:

(A) Joint ownership of property.

(B) Common ownership of an automobile.

(C) Joint bank account.

(D) A will, which designates the other as primary beneficiary.

(E) A beneficiary designation form from a retirement plan or life insurance policy designating the Domestic Partner as the primary beneficiary.

(F) If they reside in a state, which provides for registration of Domestic Partners, they have registered and provide Employer with evidence of such registration.

(G) Any other reasonable evidence of financial interdependence, within the discretion of the Plan Administrator.

(d) Must complete a notarized affidavit declaring satisfaction with the above requirements.

2.15 **"Effective Date"** means January 1, 2014, for this amended and restated Flex Plan document. The original Flex Plan was effective as of July 1, 2000.

2.16 **"Eligible Dependent Care Expense"** means an expense as defined in the Dependent Care Assistance Plan, if applicable.

2.17 **"Eligible Employee"** means each full-time Employee of Inframark and any Participating Employers, as designated in the Employer's employment policies and procedures, (who are regularly scheduled to work **30** hours per week or more and other employees as provided under the provisions of any underlying Plan), unless provided otherwise in any plan incorporated into this Plan by reference. Union Employees shall only be Eligible Employees to the extent any collective bargaining agreement specifically requires participation in this Plan.

2.18 **"Eligible Healthcare Reimbursement Expense"** means any expenses for medical, dental, vision or other health care which are not reimbursed under any insured or self-insured medical programs and which are otherwise deductible under Section 213 of the Code.

2.19 **"Employee"** means any individual who is employed by the Employer or a Participating Employer.

2.20 **"Employer"** means Inframark, LLC or any Participating Employers which adopts this Flex Plan, except where the context specifically limits the term Employer to Inframark.

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

2.22 **"Fiduciary"** means any person who:

(a) Exercises any discretionary authority or discretionary control respecting the management of the Plan or exercises any authority or control respecting the management or disposition of contributions under the Plan; or

(b) Has any discretionary authority or discretionary responsibility in administering the Plan.

2.23 **"FMLA Leave"** means a leave of absence under the Federal Family and Medical Leave Act of 1993 ("FMLA"), or any similar state leave statutes.

2.24 **"Healthcare Reimbursement Account"** means the account established for the purpose of paying Eligible Healthcare Reimbursement Expenses. In general, reference to a Healthcare Reimbursement Account shall also include the Limited Purpose Healthcare Reimbursement Account, except to the extent the context indicates otherwise.

2.25 **"Health Savings Account" ("HSA")** means a contribution to an HSA by the Company as provided in Section 4.14.

2.26 **"High Deductible Health Plan" ("HDHP")** means a Plan that can be integrated with Health Savings Accounts.

2.27 **"Highly Compensated Individual"** means an individual who is described in paragraphs (a), (b), (c), and (d) of Section 2.28.

2.28 **"Highly Compensated Participant"** means a Participant who is:

(a) An officer of the Employer or a Participating Employer (within the meaning of Section 125(e)(1)(A) of the Code);

(b) A shareholder owning more than **5%** of the voting power or value of all classes of stock of the Employer or a Participating Employer.

(c) Highly compensated (within the meaning of Section 125(e)(1)(C) of the Code); or

(d) A spouse or dependent (within the meaning of Section 152 of the Code) of an individual described in paragraphs (a), (b) or (c) above.

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

2.30 **"Individual Election Period"** means a period not to exceed **30** days commencing on the date on which an Employee first becomes an Eligible Employee, unless such period is extended in a uniform and nondiscrimination manner.

2.31 **"Initial Election Period"** means the period from October 1, 2013 through November 30, 2013, prior to the amendment and restatement of the Plan, in which Eligible Employees were allowed to make all elections under the Plan.

2.32 **"Key Employee"** means those Employees defined in Section 416(i) of the Code and the Treasury regulations thereunder, as modified or changed from time to time. Generally, they shall include any Employee or former Employee (including any deceased Employee and his Beneficiaries who at any time during the Plan Year that includes the Determination Date was an officer of the Employer having 415 Compensation greater than **$130,000** (as adjusted under Section 416(i)(1)) of the Code, a **5**-percent owner of the Employer, or a **1**-percent owner of the Employer having 415 Compensation of more than **$150,000**. The determination of who is a key employee shall be made in accordance with Code Section 416(i)(1) and the applicable regulations and other guidance of general applicability issued thereunder.

2.33 **"Limited Purpose Healthcare Expenses"** means an expense that is paid for dental or vision care services within the meaning of Revenue Ruling 2003-102.

2.34 **"Limited Purpose Healthcare Reimbursement Account"** means the account established within the records of the Plan for each Participant who allocates Employee Pre-Tax Contributions for reimbursement coverage for dental, vision or other limited expense reimbursements as provided under Section 4.6 of the Plan.

2.35 **"Medical Expenses"** or any similar term for purposes of any Health Flexible Spending Account ("FSA") should be for purposes of any Healthcare Reimbursement Account, Limited Purpose Healthcare Reimbursement Account or Health Savings Account ("HSA") shall **exclude** over-the-counter ("OTC") drugs from eligibility for reimbursement under the Flex Plan, unless they are "prescribed" by a physician within the meaning of Section 106(f) of the Code or for insulin. In addition, only medicine or drugs considered to be prescription drugs under Section 106(f), and not OTC drugs obtained under a prescription, may be purchased with debit and/or credit cards issued in connection with the Flex Plan. The Employer hereby elects to only eliminate OTC drugs for the Health FSA as required under the Affordable Care Act ("ACA").

2.36 **"Medical Plan"** means the insured or self-insured medical plan or plans maintained by the Employer, attached as **Exhibits** hereto, and incorporated into this Plan by reference.

2.37 **"Medical Premium Contribution Account"** means the Account established for the purpose of paying the cost of Eligible Employees for medical benefits selected in Article IV.

2.38 **"Nontaxable Benefit"** means any benefit received under this Plan and which, with the application of Section 125(a) of the Code, is not includable in the gross income of an Employee by reason of an express provision of chapter 1 of the Code (other than Sections 117, 124, 127 or 132 of the Code). All Nontaxable Benefits are identified in **Exhibit A**, and are hereby incorporated into the Plan by reference.

2.39 **"Non-Pre-Tax Benefits"** means the Supplemental Employee Life Insurance, the Dependent Life Insurance, and other coverages that may only be obtained through after-tax payroll deductions, outside of the Flex Plan, as identified in **Exhibit A**.

2.40 **"Non-Urgent Care"** means any medical care or treatment that is not considered Urgent Care.

2.41 **"Open Election Period"** means the period identified annually between October 1 and ending on or about the following November 30.

2.42 **"Participant"** means any Eligible Employee who has met the participation requirements of Article III and elects to participate in the Plan by execution of the Appropriate Forms.

2.43 **"Participating Employer"** means a related corporation within the Inframark single employer or controlled groups, as defined under Section 1563 of the Code, which adopt this Plan with the consent of a senior officer of the Participating Company and the consent of Inframark.

2.44 **"Plan"** means the Inframark, LLC Flexible Benefits Plan as set forth in this document, and as amended for time to time.

2.45 **"Plan Year"** means the **12** month period beginning each January 1 and ending on the following December 31of each year.

2.46 **"Pre-Service Claim"** means any claim for a benefit under this Plan where this Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care.

2.47 **"Post-Service Claim"** means any claim for a benefit that is not a claim involving Urgent Care or a Pre-Service Claim, such as a claim that is a request for payment under the Plan for covered medical services already received by a Claimant.

2.48 **"Salary Reduction Agreement"** shall mean a written agreement on an Appropriate Form prescribed by the Administrator and entered into by an Eligible Employee with the Employer under which the Eligible Employee's Compensation is reduced and the amount of such reduction is used by the Employer or any Participating Employers to provide benefits under this Plan.

2.49 **"Similar Coverage"** means coverage for the same category of benefits for the same individual (i.e., family to family, or single to single). Two plans providing major medical are considered Similar Coverage. A Healthcare Reimbursement Account is **not** Similar Coverage with a health plan. The Plan may treat coverage by another employer, such as a Spouse's or Dependent's employer, as Similar Coverage.

2.50 **"Spouse"** means, notwithstanding any language to the contrary above, the person to whom a Participant is legally married at the time of such determination, as determined under Federal law, within the discretion of the Plan Administrator, including same-sex Spouses as of

June 26, 2013, if a same-sex couple was legally married and resided in a state that recognized same-sex marriages; and as of **September 16, 2013** and thereafter, if a same-sex couple was legally married in a state or jurisdiction recognizing same-sex marriages, regardless of where they reside, as determined for purposes of Federal income taxes. The term "Surviving Spouse" means the survivor of a deceased Participant to whom such Participant was legally married (as determined by the Plan Administrator) on the date of the Participant's death.

2.51 **"Termination Date"** means the date on which a Participant ceases participation in the Plan, as determined under Section 3.4.

2.52 **"Third-Party Administrator"** means any independent legal entity empowered to administer the operations of the Plan including, but not limited to, reviewing claims for benefits and reimbursing Participants in accordance with the terms of the Plan. The Third Party Administrator for the Plan is PayFlex Systems USA (the "TPA").

2.53 **"Union Employee"** means any Employee who is included in a unit of employees covered by an agreement which the Secretary of Labor finds to be a collective bargaining agreement between the Employer and a bargaining representative of such person, if there is evidence that employee benefits were the subject of good faith bargaining between such bargaining representative and the Employer.

2.54 **"Urgent Care"** means any claim for medical care or treatment where using the timetable for Non-Urgent Care determinations could seriously jeopardize the life or health of the Claimant; or the ability of the Claimant to regain maximum functions; or in the opinion of the attending or consulting physician, which subject the Claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

2.55 **"USERRA"** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

2.56 **"Vision Plan"** means the insured or self-insured dental plan or plans maintained by the Employer or any Participating Employer, attached as an **Exhibit** hereto, and incorporated into this Plan by reference, if any.

2.57 **"Vision Premium Contribution Account"** means the account established for the purpose of paying the cost for Eligible Employees to receive benefits under the Vision Plan, if any.

2.58 **"Wellness Program"** means any programs selected by the Employer to help improve employee health, including, but not limited to smoking cessation and weight loss programs.

ARTICLE III
PARTICIPATION

3.1 **Eligibility**. Any Eligible Employee shall be eligible to participate in the Plan on the first day of such individual's employment with the Employer, or any later date determined by the Administrator in a uniform and consistent manner, or as required in accordance with the terms of any insured or self-insured welfare programs that are incorporated into the Plan; provided, however, that any Eligible Employee who desires to elect dependent care coverage must also satisfy any separate eligibility requirements under the Dependent Care Plan.

3.2 **Participation**.

(a) An Employee who was or became an Eligible Employee during the Initial Election Period became a Participant on the Effective Date, by filing with the Administrator a written election and a Salary Reduction Agreement, or on-line comparable documents, indicating that he elects to receive one or more Nontaxable Benefits under the Plan.

(b) An Employee who first becomes an Eligible Employee after the Initial Election Period ends may become a Participant, provided such Eligible Employee files with the Administrator a written election during the Individual Election Period indicating that he elects to receive one or more Nontaxable Benefit under the Plan.

(c) An Eligible Employee who does not elect to participate in the Plan during the Initial Election Period or Individual Election Period, as the case may be, may not thereafter elect to participate in the Plan until an Open Election Period, unless otherwise permitted under the Plan.

(d) Except as otherwise determined by the Administrator, in a uniform and consistent manner, if an Eligible Employee does not elect any coverages when they are first eligible for such benefits, they shall not be able to elect such coverage unless there is a change in status or a HIPAA special enrollment event.

3.3 **Failure to Make an Election**. If an Eligible Employee fails to file any form in accordance with the terms of the Plan or the administrative practices of the Administrator, such individual shall be deemed to have elected no benefits, or may be **"defaulted"** into any election choices established by the Employer in a uniform and nondiscriminatory manner, as long as such actions do not violate any state or federal wage and hour provisions. If an Eligible Employee does not elect to receive any Nontaxable Benefits, the Eligible Employee shall receive his taxable Compensation during the Plan Year, subject to any applicable tax withholdings.

For any Plan Year subsequent to the Plan Year for which a Participant has submitted a Salary Reduction Election under Section 3.2, if the Participant fails to submit a completed Election Form to the Employer for any future Plan Years, the Participant shall be deemed to have made the same elections(s) for any insurance premiums, as were in effect for the Participant on the last day of the preceding Plan Year in accordance with Section 4.8(a) within

the discretion of the Plan Administrator, and such Participant shall be deemed to have agreed to a reduction in the Participant's Compensation for the subsequent Plan Year in an amount equal to the Participant's share of the cost of all elected benefits the Participant is deemed to have elected (if the Participant had elected a similar Salary Reduction in the previous year), unless notified to the contrary. However, with respect to any Healthcare Reimbursement or Dependent Care Reimbursement Accounts, if no new annual election is made, the Employer shall assume that no such benefits have been elected for any subsequent Plan Year, as provided in Section 4.8(a).

3.4 **Termination of Participation**. An Eligible Employee who has become a Participant in the Plan in accordance with Section 3.1 shall remain a Participant until the Participant's "Termination Date". A Participant's Termination Date shall be the earlier of:

(a) The date the Participant ceases to be an Eligible Employee;

(b) The date as of which the Participant elects to discontinue participation in the Plan in accordance with the provisions of the Plan; or

(c) The date the Plan is terminated; or

(d) The **31st** day of a leave of absence for service in the uniformed services, as defined in the USERRA, or the last day of the month in which such Participant becomes a full-time member of the armed forces of any country other than the United States;

(e) With respect to medical benefits, the date on which such Participant elects Medicare as primary health insurance or, if later, the date on which such Participant becomes eligible for Medicare.

Notwithstanding the provisions of Paragraphs (a), (b), (c), (d) and (e);

(i) Nothing in this Section shall prohibit the payment of benefits with respect to claims arising prior to the Participant's termination of participation;

(ii) A former Eligible Employee who is absent by reason of sickness, Disability, or other authorized leave of absence (i.e., FMLA, or USERRA or otherwise) may continue as a Participant for so long as such authorized absence continues in accordance with such rules and regulations as the Employer may establish, within its discretion; and

(iii) To the extent set forth in any plan providing benefits hereunder, benefits payable to the surviving Spouse or Dependent of an individual whose participation ceases by reason of his death may be provided throughout the Plan Year in which the Participant died as if the Participant had survived throughout the Plan Year.

3.5 **Payment of Contributions While on Military or Family Leave**. For purposes of Section 3.4 (e)(ii), any Participant who continues participation during an unpaid Leave of Absence under FMLA or USERRA may be allowed to pay Salary Reduction Contributions to the

Flex Plan, under the Participant's Salary Reduction Agreement, in the amount that would have been withheld from his or her Compensation during the Leave of Absence ("Foregone Contributions") under one of the following methods:

(a) **Prepayment**. Before commencement of the Leave of Absence, either (A) in a lump sum **after-tax** payment; or (B) in one or more additional amounts withheld from Compensation on a **pre-tax** basis;

(b) **Pay-As-You-Go**. During the Leave of Absence, in **after-tax** payments in accordance with a schedule established by the Administrator; or

(c) **Catch-Up**. After the Participant returns to active employment with the Employer, either: (A) in a lump sum **after-tax** payment prior to the date of the Employer's payroll period next ending after the date the Participant returns to work; or (B) in a lump sum or to be withheld from the Participant's Compensation on a **pre-tax** basis during the remainder of the Plan Year in which the Participant returns to work, in accordance with administrative procedures established by the Employer.

If a Participant's unpaid Leave of Absence continues into a second Plan Year, he or she shall pay to the Flex Plan the amount of Foregone Contributions attributable to the Plan Year in which the Leave of Absence started (the "First Plan Year") before the end of the First Plan Year. Notwithstanding the above, the amount of Salary Reduction Contributions elected for a Plan Year by a Participant who takes a Leave of Absence shall not be changed, except to the extent that a change would be allowed under Section 4.8.

3.6 **Recommencement of Participation**. A former Participant shall recommence participation under the Plan during the Individual Election Period or Open Enrollment Period following the date the Employee satisfies the requirements set forth in Section 3.1, unless participation is precluded due to a change in election during the same Plan Year as provided in Section 4.8.

Subject to the provisions of Section 7.5 regarding the right to continue health coverage, a Participant who terminates employment shall cease to be a Participant as of his Termination Date under Section 3.4. If such an individual is subsequently rehired, he shall resume participation in accordance with the provisions of Section 3.2 as if he had not been previously employed, provided, however, a former active Participant who is reemployed during the Plan Year in which his Termination Date occurred and recommences participation in the Plan immediately upon his reemployment, shall be deemed to have the Benefits that were in effect immediately prior to his Termination Date, and shall be permitted to make new elections only to the extent permitted in Section 4.8. Notwithstanding any provisions to the contrary, if a former active Participant's coverage was terminated by reason of absence due to service in the uniformed services, as defined in the USERRA, and such former active Participant is reemployed within such period during which his right to reemployment is protected by law, such individual shall recommence participation in the Plan immediately upon his reemployment.

3.7 **Independent Contractors Ineligible**. No individual shall participate in the Flex Plan while such individual is actually employed by a leasing organization rather than the Employer. No individual shall participate in the Plan during a period in which the Employer considers the individual to be an independent contractor, regardless of any subsequent or retroactive reclassification of the individual.

ARTICLE IV
BENEFITS

4.1 **Nontaxable Benefits**. Each Participant may elect one or more of the following Nontaxable Benefits as further described below:

(a) Medical Premium Coverage;

(b) Dental Premium Coverage;

(c) Vision Premium Coverage;

(d) Regular Healthcare Reimbursement Coverage;

(e) Limited Purpose Healthcare Reimbursement Coverage;

(f) Health Savings Account ("HSA") Coverage;

(g) Dependent Care Reimbursement Coverage;

(h) Any other benefits identified in **Exhibit A** as of the Effective Date, or as added to the Plan in the future.

A Participant who elects one or more of the Nontaxable Benefits shall enter into a Salary Reduction Agreement to provide for contributions by the Employer to provide such Nontaxable Benefits for the Participant. One Salary Reduction Agreement may apply to one or more Nontaxable Benefits, and may cover Non-Pre-Tax Benefits that are paid outside of the Flex Plan.

The Administrator may, within its discretion, establish rules and procedures under which any Nontaxable Benefits may be paid for with **after-tax** dollars. Any benefits paid for with after-tax dollars, including any Non-Pre-Tax Benefits identified in **Exhibit A**, shall not be considered a part of this Flex Plan, even if the election of such benefits are obtained at the same time as the pre-tax Salary Reduction Elections are obtained under this Plan. One Salary Reduction Agreement may apply to one or more Nontaxable Benefits, and may cover Non-Pre-Tax Benefits that are paid **outside** of the Flex Plan.

4.2 **Medical Premium Coverage**. Each Participant who elects Medical Premium Coverage shall enter into a Salary Reduction Agreement with the Employer, pursuant to which the Participant's Compensation shall be reduced by an amount equal to the premium required for the optional coverage selected by the Participant under the Medical Plan or any future Medical Plan or programs implemented by the Employer. If multiple Medical Plans are in existence, Medical Premium Coverage may be elected under any such Medical Programs. All contributions for medical care coverage and the payment of all benefits shall be governed by the Medical Plan or Plans, unless otherwise limited or restricted by the Plan. Participant Salary Reduction

Agreements for medical coverage may be **automatically** adjusted during any Plan Year, for any increases in premiums declared by any insurance carriers.

Notwithstanding any provisions to the contrary, in no event may any COBRA premiums be paid on a pre-tax basis under the Flex Plan.

4.3 **Dental Premium Coverage**. Each Participant who elects Dental Premium Coverage shall enter into a Salary Reduction Agreement with the Employer, pursuant to which the Participant's Compensation shall be reduced by an amount equal to the premium required for dental care coverage selected by the Participant under the Dental Plan, or any future Dental Plan or programs implemented by the Employer. All contributions for dental coverage and the payment of all benefits shall be governed by the Dental Plan, unless otherwise limited or restricted by the Plan. Participant Salary Reduction Agreements for dental coverage may be **automatically** adjusted during any Plan Year, for any increases in premiums declared by any insurance carriers.

4.4 **Vision Premium Coverage**. Each Participant who elects Vision Premium Coverage shall enter into a Salary Reduction Agreement with the Employer, pursuant to which the Participant's Compensation shall be reduced by an amount equal to the premium required for vision care coverage selected by the Participant under the Vision Plan, or any future Vision Plan or programs implemented by the Employer. All contributions for vision coverage and the payment of all benefits shall be governed by the Vision Plan, unless otherwise limited or restricted by the Plan. Participant Salary Reduction Agreements for vision coverage may be **automatically** adjusted during any Plan Year, for any increases in premiums declared by any insurance carriers.

4.5 **Regular Healthcare Reimbursement Coverage**. Each Participant is entitled to elect to reduce the Participant's Compensation to make contributions to a Regular Healthcare Reimbursement Account. Each Participant who elects Healthcare Reimbursement Coverage shall enter into a Salary Reduction Agreement with the Employer, pursuant to which the Participant's Compensation shall be reduced in an amount not to exceed **$3,050** for the 2023 Plan Year, or any other amount determined by the Employer or any Participating Employer prior to the beginning of any Plan Year, with a minimum required contribution amount as determined by the Administrator, and applied in a uniform and consistent manner. The **$3,050** maximum contributions **shall not be prorated** based upon the number of payroll cycles remaining in any Plan Year in which a Participant does not participate in the Plan for a full Plan Year. Thus, the full **$3,050** may be contributed regardless of when a Participant enters the Plan.

Contributions made to a Healthcare Reimbursement Account shall be available to pay for unreimbursed Eligible Healthcare Reimbursement Medical Expenses incurred by a Participant, a Participant's Spouse or eligible Dependents, including unreimbursed medical expenses under the Employer's Medical Plan, or the plan of any Spouse or Dependent, whether unreimbursed because of any plan's deductibles, coinsurance requirements, maximum benefit limitations or because an expense is excluded from coverage. In no event, however, is a Participant entitled to reimbursement from his Healthcare Reimbursement Account if any

medical expense is reimbursed or eligible for reimbursement under any insured or self-insured plan maintained by any employer of the Participant, any Spouse or Dependent, unless reimbursement is otherwise required under State coordination of benefit rules.

a **2½ Month Rule**. Consistent with IRS Notice 2005-42, participants in the Flex Plan were permitted to submit expenses for reimbursement that are incurred up to **2½** months after the end of each Plan Year. This rule shall apply to the Healthcare Reimbursement Account, and the Limited Purpose Healthcare Reimbursement Account established under the Flex Plan for the 2013 Plan Year, into 2014. The Plan Administrator shall establish reasonable administrative procedures to address the **2½** month Grace Period.

b. **Eligibility for the 2½ Month Rule**. Participants shall be eligible to submit reimbursement for Eligible Healthcare Reimbursement and the Limited Purpose Healthcare Reimbursement, as long as the participant is either an active participant in the Plan on December 31, 2013, or has elected COBRA coverage for purposes of the Medical Expense or Limited Purpose Reimbursement Account. To the extent that an individual is not an active participant on December 31 of any Plan Year and/or has not elected COBRA coverage for purposes of the Healthcare or Limited Purpose Reimbursement Accounts, only expenses incurred during the Plan Year, while an active Participant, shall be reimbursed.

4.6 **Limited Purpose Healthcare Reimbursement Account**. The Employer has established a High Deductible Health Plan ("HDHP") for participants. Participants participating in the HDHP are not eligible for reimbursement for certain Medical Expenses under the Healthcare Reimbursement Account. Participants who utilize the HDHP and a Health Savings Accounts ("HSA") may only be reimbursed for Dental and Vision benefits up to **$3,050** in 2023 under a Limited Purpose Healthcare Reimbursement Account (the "Limited Purpose "FSA"). Accordingly, effective as of January 1, 2023 or such other date as established by the Plan Administrator, a Limited Purpose FSA may be established for purposes of Participants utilizing the HSA. All other administrative and other provisions applicable to the Health Reimbursement Account, including the requirements to submit claims and other provisions shall apply to the Limited Purpose Healthcare Account.

4.7 **Healthcare Reimbursement Account Annual Rollover**. Under IRS Notice 2013-71, the Employer elects, effective as of January 1, 2014, to implement an annual Healthcare Reimbursement Account Rollover of up to **$570** for the 2023 Plan Year (increased to **$610** (**20%** of **$3,050** for the 2023 Plan Year)). This provision shall permit up to **$570** of unused funds in the Healthcare Reimbursement Account to be transferred from the 2022 to the 2023 Plan Years. The **$570** or other Rollover does not reduce the annual **$3,050** maximum Healthcare Reimbursement Account limitation for 2023, as revised in accordance with the Code. Thus, for purposes of the 2023 Plan Year, a Participant may have up to **$3,620** (**$3,050** + **$570**) available for use under a Healthcare Reimbursement Account. The Healthcare Reimbursement Account Rollover shall apply to all future Plan Years in the same manner. Notwithstanding any provisions in the Plan to the contrary, the **2½** month "grace period" shall not apply at the end of the 2022 or any future Plan Years.

For purposes of "ordering", Rollover funds shall be used first, before any Employer or Employee Contributions for the current Plan Year.

The Plan Administrator may establish reasonable procedures to implement, communicate and administer the rollover Health FSA contribution in accordance with IRS Notice 2013-71 and any future guidance.

4.8 **Dependent Care Coverage**. Each Participant who elects Dependent Care Coverage shall enter into a Salary Reduction Agreement with the Employer pursuant to which the Participant's Compensation shall be reduced by an amount elected by the Participant and credited by the Employer to the Participant's Dependent Care Reimbursement Account in accordance with the Dependent Care Assistance Plan.

Contributions to any Participant's Dependent Care Reimbursement Account shall be made in accordance with the terms of this Plan and the Dependent Care Assistance Plan, but in no event may the contributions subject to reimbursement exceed **$5,000** in any taxable year, or **$2,500** in the event a separate federal income tax return is to be filed for any taxable year by a Participant who is married.

The Employer and all Participating Employers have **elected** to continue to allow Participants to be reimbursed for Eligible Dependent Care Expenses incurred within **2½** months after the end of each Plan Year.

4.9 **Revocation and Changing of Elections**.

(a) **General**. Except as otherwise specifically provided in Sections 4.9(b), (c) or (d), a Participant's election to receive a Nontaxable Benefit and the related Salary Reduction Agreement shall remain in effect until the last day of the Plan Year to which such election and Salary Reduction Agreement apply. During each Open Election Period, each Participant shall be entitled to elect, in writing, or through any other 800 number, internet or other procedures established by an employer, the same or different Nontaxable Benefits for the following Plan Year and the same or different rate of contributions pursuant to a Salary Reduction Agreement, subject to the limitations of Article V. If the Participant does not make a new election during an Open Election Period for any Medical, Dental and Vision Premium coverage, the Participant's then current election, if any, shall **automatically** continue in effect for the next Plan Year, unless a change is otherwise permitted in accordance with Sections 4.9(b), (c) and (d). If a Participant does not make a new election during an Open Enrollment Period for any Healthcare Reimbursement or Dependent Care Reimbursement coverages, or for any other Nontaxable Benefits within the discretion of the Plan Administrator, the Participant's current election shall **terminate** at the end of the Plan Year in which an election to receive such benefits was made, unless a change is otherwise permitted in accordance with Sections 4.9(b), (c) and (d). If a Participant elected to waive any coverages, such an election shall **automatically continue** in effect for the next Plan Year, unless a change is otherwise permitted in accordance with Sections 4.9(b), (c) and (d). Notwithstanding any provision to the contrary, in situations in which new annual elections are required, the Employer may notify Participants that their prior elections shall

be continued during any Open Enrollment Period, within the discretion of the Plan Administrator, unless a Participant affirmatively elects otherwise. The ability to establish new procedures under the preceding sentence shall be applied in a uniform and nondiscriminatory manner.

(b) **Other Qualifying Events**. Upon the occurrence of any of the following events, the Administrator may, within its discretion, permit Participants to make a prospective election, in writing or in accordance with any other procedures established by the Plan Administrator (i.e., fax, internet, 800 number, etc.), on an Appropriate Form or other method prescribed by the Administrator to change the Nontaxable Benefits elected under the Plan, and the related Salary Reduction Agreement, subject to the other limitations of the Plan. Other "qualifying events" shall include:

(i) **Significant Cost Increase**. A significant increase in the premium or cost of a health plan provided by an independent third-party provider. Upon the occurrence of this event, the Administrator may permit Participants to either make a corresponding change in their premium payments, or to revoke their elections and, in lieu thereof, receive coverage on a prospective basis under another health plan with similar coverage.

(ii) **Significant Curtailment**. A significant curtailment or cessation of coverage under any health plan provided by any independent third-party. Upon the occurrence of this event, Participants may be permitted to revoke their elections and, in lieu thereof, to elect to receive coverage on a prospective basis under another health plan with similar coverage.

(iii) **Separation**. A separation from service with the Employer. Upon the occurrence of this event, the Administrator may permit a Participant to revoke an election and terminate the receipt of benefits for the remainder of the Plan Year. The Participant is, however, prohibited from making any new elections for the same Plan Year if the Participant returns to service during the same Plan Year, except as otherwise allowed under Section 3.6.

(iv) **Nonpayment**. Failure of a Participant to make any required premium or contribution payments. Upon the occurrence of this event, the Participant is prohibited from making any new benefit elections during the Plan Year in which a failure to pay premiums or contributions occurred, except as otherwise allowed under Section 3.6.

(v) **HIPAA**. Any event as necessary to comply with the provision of the Health Insurance and Accountability Act of 1996 ("HIPAA") or the regulations under Section 125 of the Code. In order for any change in a Participant's election to be effective, it must be **consistent** with the reason for which a change is permitted, within the discretion of the Administrator, unless such action is otherwise permitted under HIPAA.

(vi) **Status or Cost Changes**. Any status or cost changes discussed in Section 4.9(d).

(c) **2001 Regulations Regarding Election Changes**. Under the Final 2001 Regulations, except as indicated elsewhere, the following provisions apply in accordance with the 2000 Regulations and the 2001 Regulations for purposes of allowing Participants to make changes in election for medical, dental, vision and other welfare elections, and Medical and Dependent Care Reimbursement Accounts, and to address other changes, as applicable under all tax rules, in the same manner as permitted under Sections 4.9(a), (b) and (c) (i.e., in writing, internet, etc.). However, unless otherwise noted, these provisions do not apply to and shall not result in any election changes to the Healthcare Reimbursement Accounts under the Plan.

(i) **Automatic Changes in Employee Contributions for Cost Changes**. If the cost of any qualified benefit increases, or decreases, during a period of coverage, Participants shall automatically be required to have an adjustment made to their Salary Reduction Agreements, on a prospective basis to increase, or decrease the amount of Employee contributions, on a reasonably consistent basis. A cost increase or cost decrease refers to an increase or decrease in the amount of Employee contributions to the Plan as a result of actions taken by the Employee (i.e., switching between full-time and part-time status) or by the Employer (i.e., reducing an amount of Employer contributions for a class of Employees, or as a result of mid-year increases in premiums.)

(ii) **Significant Cost Increase**. In the event that the cost of any benefits significantly increases during a period of coverage, or if it is determined that Participants must contribute a larger portion of the total cost of the Plan, the Plan shall allow Participants to make a corresponding change in election. In the case of an increase in cost, the Participants may either elect to make a prospective increase in their payments, or to revoke their elections and to receive prospective coverage under another Benefit Package Option providing similar coverage, or to drop coverage if no other benefit package providing similar coverage is available (i.e., including a change from family to single coverage). For purposes of any Dependent Care Reimbursement Account, this provision shall only apply if a Dependent Care provider is not a relative of the Participant. Furthermore, this provision does not apply to any Healthcare Reimbursement Accounts.

(iii) **Significant Cost Decrease**. In the event that the cost of any benefits significantly decreases during a period of coverage, the Plan may allow Participants to decrease Salary Reduction contributions by an amount that corresponds to the premium change or shall allow Participants and non-Participants to elect to participate (or enroll) in the option with a decrease in cost.

(iv) **Significant Curtailment With Loss of Coverage**. If the coverage under any benefit program for a Participant, Spouse or Dependent is significantly curtailed, as defined below, resulting in a loss of coverage, as defined below, the Plan may permit the affected Participants to revoke their elections and to make new elections on a prospective basis for coverage under another Benefit Package Option providing similar coverage, or to drop coverage if no similar Benefit Package Option is available. For purposes of this Amendment, loss of coverage means a complete loss of coverage under the Benefit Package Option, including:

(A) An elimination of a Benefit Package Option;

(B) An HMO ceasing to be available in the area where an Employee resides;

(C) An Employee losing coverage under an option by reason of an overall lifetime or annual limitation;

(D) A determination by the Administrator on a discretionary basis of:

(1) A substantial decrease in the medical care providers available under a Benefit Package Option (i.e., not the loss of a particular physician);

(2) A reduction in the benefits for a specific type of medical condition or treatment with respect to which the Employee, Spouse or Dependent is currently in a course of treatment; or

(3) Any other similar fundamental loss of coverage as determined within the discretion of the Plan Administrator.

(v) **Significant Curtailment Without Loss of Coverage**. If the coverage under any benefit program is significantly curtailed for a Participant, Spouse or Dependent during a period of coverage but is not a loss of coverage, as described above (i.e., there is a significant increase in the deductible, the copay, or the out of pocket cost sharing limit), the Plan may permit affected Participants to revoke their elections and to make new elections on a prospective basis for coverage under another Benefit Package Option providing Similar Coverage. With regard to health coverage, a significant curtailment shall only exist if there is an overall reduction in coverage provided to Participants under the underlying plan, so as to constitute reduced coverage to Participants generally. This provision does **not apply** to any Healthcare Reimbursement Accounts.

(vi) **Addition (or Elimination) of Benefit Package Option**. In the event of the addition of a new Benefit Package Option or of a coverage option, or the elimination of any existing Benefit Package Option or other coverage, the Plan may permit affected Eligible Employees to elect the newly added option, or elect another option if an option has been eliminated, on a prospective basis with respect to benefit packages providing Similar Coverage. However, Healthcare Reimbursement Account elections may generally **not be changed** as a result of changes in coverage of a Spouse, a former Spouse or a Dependent under another employer's plan.

(vii) **Significant Improvement of Benefit Package Option**. In the event of significant improvement in the coverage provided under a Benefit Package Option, the Plan may permit all Eligible Employees to elect on a prospective basis the improved option.

(viii) **Change in Coverage of Spouse or Dependents Under Another Employer's Plan**. If a change in coverage occurs for a Spouse, a former Spouse or Dependent under the terms of a plan of another employer covering such individuals, the Plan may allow a prospective election change that is on account of and corresponds with such change if the cafeteria plan or qualified benefit plan of the Spouse's, former Spouse's, or Dependent's employer permits participants to make an election change that is otherwise permitted under the Code or a cafeteria plan document. The Plan permits Participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan or qualified benefit plan of the Spouse's, former Spouse's, or Dependents' employer. However, Healthcare Reimbursement Account elections may generally **not be changed** as a result of changes in coverage of a Spouse, a former Spouse or a Dependent under another employer's plan (or upon the addition or elimination of benefit packages providing similar coverage, as noted above).

(ix) **Loss of Coverage Under Another Employer's Plan.** If a loss of coverage occurs for the Employee, the Spouse, former Spouse or Dependent under the terms of a plan sponsored by a governmental or educational institution, as defined in the 2001 Regulations, covering such individuals, the Plan shall allow a prospective election to add coverage for the Employee, Spouse, former Spouse or Dependent who lost coverage. This provision also applies to a loss of coverage under a group health plan sponsored by a governmental or educational institution, such as a state program under the State Children's Health Insurance Program ("SCHIP"), a medical care program of an Indian Tribal government, the Indian Health Services, a tribal organization, a state health benefits risk pool, or a foreign government group plan.

(x) **Special Requirements Relating to FMLA**. A Participant taking leave under FMLA may revoke an existing election and make such other election for the remaining portion of the period of coverage as may be provided under FMLA as follows:

(A) Any Participant may elect to terminate or suspend his or her participation under the Medical, Dental or Vision Plans and/or Medical or Dependent Care Reimbursement Accounts during a Leave of Absence (paid or unpaid) granted by the Employer pursuant to FMLA, effective on the first day of the payroll period coinciding with or next following such election.

(B) A Participant may reinstate his or her participation upon his or her return to active employment, subject to any requirements regarding prorated credits or contributions.

(C) No Salary Reduction Agreements shall be used to provide benefits which the Participant has elected to suspend or terminate.

(D) Upon reinstatement of participation following a Leave of Absence, any changes made to prior elections.

(E) Similar rules shall be established for military and other leave of absences, within the discretion of the Administrator, and consistent with all regulations.

(xi) **HIPAA**. Upon the occurrence of any event which qualifies as a **"special enrollment"** as allowed under Section 9801(f) of the Code as enacted under HIPAA, such as the special enrollment periods under which employees may request enrollment under a plan within **31** days after a loss of coverage that was available when an employee was otherwise eligible to elect coverage; and upon the marriage of a Participant, or the birth, adoption or placement for adoption of a child, the Plan may permit a change in election under a group health plan (not a Dependent Care Plan). A Participant may make a retroactive election for coverage only in cases of birth, adoption or placement for adoption within **31** days of the birth, adoption or placement for adoption. Any changes allowed under the special enrollment rules shall permit contributions to be paid on a **pre-tax** basis.

(xii) **Support Order**. Upon the receipt of a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order under Section 609 of ERISA) that requires accident or health coverage for a Participant's child. Coverage for the child required under a judgment, decree or order may be cancelled only if the Participant's Spouse or former Spouse, or another individual to provide coverage, actually procures coverage for the child. The Plan may:

(A) Automatically change the Participant's salary reduction elections to provide any such child's health coverage (if the order requires such coverage); or

(B) Permit the Participant to elect to cancel the child's health coverage (if the order requires the Spouse, former Spouse, or another individual to provide coverage).

(xiii) **Medicare or Medicaid**. Upon entitlement of a Participant, Spouse or Dependent to coverage (i.e., enrollment) under Part A or Part B of the Title XVIII of the Social Security Act (Medicaid), or Title XIX of the Social Security Act (Medicare), the Plan may permit a Participant to change the Participant's election in order to cancel that person's group health coverage. Similarly, any loss in such coverage shall entitle a Participant to elect to commence or increase coverage under the Plan for the Participant, Spouse or Dependent.

An eligible employee (or dependents) that qualifies for CHIP coverage must request group coverage no later than **60** days after the date eligibility is determined.

An Eligible Employee may also elect to enroll in group coverage within **60** days of the loss of Medicare or CHIP coverage.

(xiv) **Change in Status**. Change in status events, where the election change is on account of and corresponding with a change in status event that affects coverage, under the 2001 Regulations, permitting changes for health coverage, disability coverage, if provided, and group-term life insurance, include the following:

(A) Events that change an Employee's legal marital status, including marriage, death of a Spouse, divorce and legal separation or annulments.

(B) Events that change increase or decrease an Employee's number of Dependents, including birth, death, adoption and placement for an adoption (as defined in the regulations under Section 9801 of the Code).

(C) The termination or commencement of employment by the Participant, Spouse or Dependent.

(D) A reduction or increase in hours of employment by the Participant, Spouse, or Dependent, including a switch between part-time and full-time, a strike or lock-out, a change in worksite or commencement or return from an unpaid leave of absence. For purposes of this provision, any change in the employment status of a Participant, Spouse or Dependent resulting in such an individual becoming, or ceasing to be, eligible under any plans (i.e., if an individual changes from salaried to hourly status, etc.).

(E) An event that causes a Participant's Dependent to satisfy (or to no longer satisfy) a group health plan's coverage requirements due to reaching an age, student status or any similar circumstances as provided in the employer's health plan.

(F) A change in the place of residence or place of work of the Participant, Spouse or Dependent. However, this change does not affect the Participant's eligibility or election to make any changes under the Healthcare Reimbursement Account.

The Employer may require a Participant to demonstrate the existence of or satisfaction of any change in status within its discretion, applying uniform and nondiscrimination rules. Any Employee who wishes to decrease or cancel health coverage due to eligibility under a Spouse's or Dependent's plan, resulting from marital or employment change in status may do so only by providing to the Administrator certification that the Employee has or shall obtain coverage under the plan of the Spouse or Dependent. If the Administrator has reason to believe the certification is incorrect, the Administrator may deny the request to cancel or decrease health coverage. The Employer may also establish reasonable rules and regulations governing the time within which a Participant must make a revocation and new election.

(xv) **COBRA Coverage**. Upon entitlement to elect continuation health coverage under COBRA or any similar state laws, a Participant may not be allowed to elect to increase payments under the Plan in order to pay for continuation health coverage of the Participant, a Spouse or any Dependents under this Plan, to the extent any Compensation is being paid to the Participant.

(xvi) **Section 401(k) Elections**. Notwithstanding any provisions to the contrary, elections under a plan established under Section 401(k) of the Code may be modified or

revoked in accordance with Sections 401(k) and (m) of the Code without any limitations regarding this Plan.

(xvii) **Consistency Rule**. Notwithstanding any provisions to the contrary, to the extent required in the 2000 or 2001 Regulations, election changes shall only be honored to the extent a change in coverage is **"consistent"** with the reasons for which a change is being effectuated as required by such Regulations. The Plan shall comply with all nondiscrimination rules as required under Section 125 and 129 of the Code. Furthermore, the Plan shall comply with the new privacy and nondiscrimination rules when they become effective under HIPAA, and any other nondiscrimination rules enumerated in any statutes or regulations. Situations in which elections **must be consistent** include the following:

For accident or health coverage, the consistency rule requires that any Participant who wishes to decrease or cancel coverage because he or she becomes eligible for coverage under a Spouse's or Dependent's plan due to a marital or employment change of status, can do so only if he or she actually obtains coverage under that other plan. An Employer may rely upon an Employee's certification that he has or shall obtain other coverage, unless the Employer has reason to believe that the certification is incorrect.

(d) **Negative Balances**. Notwithstanding any other provision of the Plan to the contrary, under no circumstances may an Eligible Employee elect to decrease any Salary Reduction Agreement if there is a **negative balance** in any Accounts under the Plan.

(e) **Procedures**. The Employer may establish reasonable procedures to determine if any event is a "change in status" allowing a Participant, Spouse or Dependent to change any elections allowed under the Plan. The procedures may take into consideration any events, even if such events are not identified in the Section 125 Plan, in accordance with any guidance issued by the IRS or any other government agencies. Furthermore, in the event any event listed in the Plan is subsequently held not to be a change in status or other event to allow any elections to be revised, such a provision of the Plan shall be considered to be ineffective, and shall not be followed, to preserve the beneficial tax treatment granted to the Plan.

(f) **Dependent Care**. Changes in dependent care service providers, as well as increases in Compensation, shall allow election changes for Dependent Care Reimbursement Accounts, even though such actions shall not allow changes for medical or other elections.

4.10 **Reimbursement**. Subject to the limitations contained in other provisions of this Plan, a Participant who incurs Eligible Healthcare Reimbursement, Limited Purpose Healthcare Reimbursement or Dependent Care Expenses during a Plan Year shall be entitled to receive from the Plan full reimbursement for the entire amount of such expenses to the extent of the amount to be credited to the Participant's Healthcare Reimbursement Account or the amount credited to the Participant's Dependent Care Reimbursement Account for that Plan Year. The Administrator shall pay all such expenses to the Participant upon the presentation to the Administrator, or to a Third-Party Administrator designated by the Administrator, of documentation of such expenses on an Appropriate Form. A Participant may submit a request for reimbursement of Eligible

Healthcare Reimbursement or Eligible Dependent Care Expenses as frequently as permitted by the Administrator, including any minimum reimbursement amounts. A Participant must submit a final request for reimbursement for Eligible Healthcare Reimbursement or Eligible Dependent Care Expenses incurred during a Plan Year not later than **4** months (i.e., a "Run Off Period") after the end of the Plan Year, and such final request may be for less than any minimum amount. Likewise, a Participant who terminates the Participant's participation in the Plan must submit a final request for reimbursement of Eligible Healthcare Reimbursement or Eligible Dependent Care Expenses incurred prior to his or her Termination Date not later than any period after such Termination Date established by the Administrator, and such final request may be for less than any minimum amounts.

If a Participant dies during the Plan Year, the Participant's surviving Spouse, or, if none, Participant's personal representative, may submit requests for reimbursement in accordance with this Section.

4.11 **Adjustment of Salary Reduction**. The Administrator shall have the right to adjust any elections made under the Plan, and any benefit election, to ensure that the Plan and all underlying plans comply with any applicable nondiscrimination requirements of the Code, including but not limited to Section 79, 105, 125 and 129.

4.12 **Forfeiture of Employee Contributions**. If, following the final payment of premiums for medical, dental or vision care coverage, and the final reimbursement of Eligible Healthcare Reimbursement, Limited Purpose Healthcare Reimbursement or Eligible Dependent Care Reimbursement Expenses incurred during the Plan Year, any amount remains in any Accounts for that Plan Year, the Participant shall **forfeit** such amount to the Employer, except to the extent of the new **$500** Rollover Rule contained in Section 4.7.

4.13 **Premium Payments**. Upon the termination of a Participant's employment, the full amount of all regular premium contributions shall be withheld through the Participant's date of termination, without any proration for partial periods. For example, if a Participant terminates on the first day of a new payroll cycle, the entire amount of premium contributions shall be withheld even if coverage is terminated as of the date of termination.

4.14 **Health Savings Accounts**. If a Participant elects to participate in the High Deductible Health Plan, Inframark shall make contributions to a Health Savings Account ("HSA"), as determined by Inframark, on an annual basis, within its discretion.

(a) **Inframark HSA Contributions**. Inframark contributions for the 2014 and 2015 calendar year are as follows:

Status	**Inframark Contributions**
Individual:	**$500** annual contribution made at the beginning of each Plan Year or when an HSA is established during any Plan Year.

Family: **$1,000** annual contribution made at the beginning of each Plan Year or when an HSA is established during any Plan Year.

If a Participant does not spend all of the contributions made to a Participant's HSA on an annual basis, funds **remain in a Participant's HSA** from year to year and are **not lost** under the "use it or lose it" rules. The HSA Contribution is **not prorated** if any Participant enters the Plan during any Plan Year.

(b) **Withdrawals**. Withdrawals from a Participant's HSA are limited to the balance in each Participant's HSA Account as maintained with Optum, or any other financial institution that facilitates the implementation of HSAs in the future. Funds for eligible medical expenses may be accessed as follows:

(i) A Debit Card may be used for HSA expenses at qualified merchants.

(ii) Funds may be transferred on-line to reimburse a Participant or to pay a Vendor directly.

(iii) In accordance with any reasonable procedures established by the applicable financial institution and the Plan Administrator, in accordance with the Code.

Regardless of how funds from an HSA are accessed, a Participant is responsible for maintaining all documentation and receipts to prove that funds from an HSA are used for eligible medical expenses, if ever questioned by the IRS.

4.15 **Health FSA Cost of Living Increases**. In Revenue Procedure 2014-61, the IRS increased the Health FSA limit from **$2,500** to **$2,550** effective as of January 1, 2015. The Employer elects not to implement this increase. Increases in the annual FSA contribution limitation shall be implemented, within the discretion of the Plan Administrator, and as communicated to employees, in recognition that the cost of living increase may periodically be announced without sufficient time to include an increase in annual open enrollment materials.

4.16 **Mid-Year Changes for Health Premiums (Not FSAs)**. Under ACA, employees who have a reduction in hours are **still eligible** for health coverage during a "Stability Period" as defined under ACA, and, therefore, may not change an election for health coverage. Therefore, IRS Notice 2014-55 permits mid-year election changes, as follows:

a. **Mid-Year Elections Permitted Due to Reduction in Hours**. A mid-year election change, due to a reduction in hours, **shall be permitted** if:

i. A Participant was reasonably expected to average at least **30** hours of service, and there is a change in the Participant's status, so the Participant shall reasonably be expected to average less than **30** hours of service per week after the change, even though the reduction does not result in the employees ceasing to be eligible under the group health plan

under the ACA "Look-Back" rule; and

ii. The revocation of the election of coverage must correspond to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another health plan that provides minimum essential coverage, with the new coverage effective **no later than the first day of the second month following the month that includes the date the original coverage is revoked**.

Due to the "consistency requirement" that applies to mid-year Flex Plan changes, a Participant with reduced hours may **not drop** coverage altogether. Instead, he or she must obtain coverage elsewhere, either through an Exchange or Marketplace health plan, under a Spouse's health plan or from some other source.

b. **Reasonable Representations**. Under the above new rules, the Employer shall be permitted to rely on the **"reasonable representation"** of an employee that he or she, and related individuals, have enrolled, or intend to enroll, in other health coverage when a change is made.

4.17 **Automatic Adjustment of Employee Contributions for Wellness Benefits**. The Employer maintains various wellness programs, to encourage employees to maintain healthy lifestyles. Under the terms of the wellness programs, employees may be given credits, or penalties, in order to encourage employees to not use tobacco products and to encourage other wellness initiatives. Notwithstanding any provisions in the Plan to the contrary, in the event that a Participant in the Plan fails to abide by the provisions of any wellness programs, resulting in an increase in a Participant's health plan contributions or a loss or reduction of a Participant's costs, such increases and decreases shall automatically occur under the provisions of the Plan. Thus, a change in premium contributions shall occur automatically, during the course of a Plan Year, without a change in any elections and without a change in status. This result occurs because Participants elect, prior the commencement of each Plan Year, to pay for the amount of Participant costs, as determined by the Employer prior to the commencement of each Plan Year, are subject to automatic increases and decreases for wellness programs.

ARTICLE V
LIMITATION AND NONDISCRIMINATION RULES

5.1 **Limitation on Benefits for Key Employees**. In the event the Nontaxable Benefits to be provided for Key Employees in any Plan Year exceed **25%** of the aggregate of such Nontaxable Benefits to be provided for all Employees under the Plan in such Plan Year, as determined under Section 125(b)(2) of the Code, the Administrator shall not give effect to the Elections made by Key Employees for the Plan Year to the extent necessary to reduce such benefits to be provided for Key Employees to less than **25%** of the aggregate of such Nontaxable Benefits to be provided for all Employees. In the event this required reductions does not occur, the exclusion from gross income for benefits received under the Plan shall not be available to Key Employees.

5.2 **General Nondiscrimination Provision**. The Plan is intended not to discriminate in favor of Highly Compensated Individuals as to eligibility to participate. The Plan is also not intended to discriminate in favor of Highly Compensated Participants with respect to contributions or benefits under the Plan. If, in the judgment of the Administrator, the Plan so discriminates, the Administrator shall select and exclude from coverage under the Plan such Participants as necessary to eliminate any discrimination. The Administrator may also, within its discretion, reduce any Salary Reduction Amounts, contributions or benefits under the Plan as necessary to assure that the Plan does not discriminate in favor of any group, as intended under the Code. In no event, however, shall the Plan be treated as being discriminatory with respect to any health benefits if in accordance with Section 125(g)(2) of the Code:

(a) Contributions under the Plan on behalf of each Participant include an amount which:

(i) Equals **100%** of the cost of health benefit coverage under the Plan of the majority of the Highly Compensated Participants similarly situated; or

(ii) Equals or exceeds **75%** of the cost of the health benefit coverage of the participants, similarly situated, having the highest cost health benefit coverage under the Plan; and

(b) Compensation or benefits under the Plan in excess of those described in paragraph (a) above, bear a uniform relationship to Compensation.

If the Plan is determined to be discriminatory in any Plan Year, the exclusion from gross income available under Section 125(a) shall not apply to Highly Compensated Participants.

5.3 **Year of Inclusion**. In the event any Highly Compensated Participant or Key Employee must recognize any gross income under this Plan as a result of any violation of the Key Employee limitations or nondiscrimination rules, such income shall be recognized in the taxable year of the Key Employee or Highly Compensated Participant in which the Plan Year

ends.

ARTICLE VI
FUNDING AND EXPENSES

6.1 **Accounting**. The Nontaxable Benefits provided herein shall be paid by the Employer through contributions made under Salary Reduction Agreements reflecting such amounts of Compensation as a Participant elects to forego pursuant to a Salary Reduction Agreement and credited under each Participant's Accounts. The Administrator shall maintain, or cause to be maintained, a separate Account for each Participant electing to contribute to a Medical Premium, Dental Premium Contribution Account, Healthcare Reimbursement, Limited Purpose Healthcare Reimbursement or Dependent Care Reimbursement Account coverage, which Accounts shall contain a complete record of all amounts to be credited as a contribution or debited as a payment of benefits on behalf of each Participant each Plan Year.

6.2 **Expenses**. Any expenses incurred in the administration or operation of the Plan shall be paid directly by the Employer. The Employer may, however, use any forfeitures to pay the administrative expenses associated with the Plan, including any accounting, legal, and consulting fees.

6.3 **Funding**. All contributions hereunder shall be held as part of the general assets of the Employer or any Participating Employer and no trust fund shall be established, and no other segregation or investment of assets shall be made to maintain account of contributions under this Plan. A Participant who enters into a Salary Reduction Agreement shall be a general unsecured creditor of the Employer or any Participating Employer with respect to any salary reduction amount which has not been expended to provide benefits for the Participant. Participants shall not be entitled to any interest or earnings on any amounts contributed to the Plan.

ARTICLE VII
ADMINISTRATION

7.1 **Duties of the Administrator**. The Employer, as the Administrator, shall have the following responsibilities and obligations for the administration of the Plan:

(a) To provide such forms as Eligible Employees or Participants may require to elect to participate in the Plan, select benefits, agree to salary reduction, or exercise any other right granted to the Participants in this Plan;

(b) To make available to all Eligible Employees any information necessary for the Employee to make a reasonable decision concerning his or her right to any election or benefit under this Plan;

(c) To maintain, or cause to be maintained, an accounting for the Medical Premium, Dental Premium, Healthcare Reimbursement and Dependent Care Reimbursement Accounts;

(d) To pay premiums for the group medical and dental care coverage payable from salary reduction contributions;

(e) To determine the right of any Participant to reimbursement from his or her Healthcare Reimbursement or Dependent Care Reimbursement Accounts, and to pay any valid claims, or to engage a Third-Party Administrator to perform this function unless such responsibility is otherwise delegated or controlled by the terms of an insurance contract;

(f) To prepare and file any annual or other reposts as it deems appropriate to inform Participants of the balance in their Healthcare Reimbursement and Dependent Care Reimbursement Accounts, if any, or other information pertaining to the operation of the Plan;

(g) To prepare and file any annual or other reports as it may determine are required by the Internal Revenue Service, Department of Labor, or any other government agency, with respect to the Plan.

7.2 **Rights and Powers of the Administrator**. The Administrator shall have the authority and power necessary to discharge its duties under the Plan, including, but not limited to the following:

(a) To construe and interpret the Plan, decide all questions of eligibility, and determine the amount, manner and time of payments of any benefit under the Plan;

(b) To prescribe procedures to be followed by Participants when electing or applying for any benefits;

(c) To prepare and distribute information explaining the Plan;

(d) To request and receive from Eligible Employees and Participants any information necessary for the proper administration of the Plan;

(e) To appoint or contract with a person or corporation to process the claims for benefits from the Healthcare Reimbursement and Dependent Care Reimbursement Accounts, if any;

(f) To appoint or contract with any other persons or agents to assist with the administration of the Plan or render advice or service, including, but not limited to legal, medical, accounting or clerical services;

(g) To pay the cost of any services or administrative expenses out of Employer funds or any financial surplus arising from Plan funds, such as insurance dividends;

(h) To delegate to any person or entity or any employee of the Employer its power and authority under the Plan; and

(i) To establish any rules necessary for the administration of the Plan.

7.3 **Liability**. Neither the Employer nor any of its officers or employees shall be liable for any loss due to its error or omission in administration of the Plan unless the loss is due to the gross negligence or willful misconduct of the party to be charged or is due to the failure of the party to be charged to exercise a fiduciary responsibility with the care, skill, prudence and diligence under the circumstances that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with the aims.

7.4 **Indemnification**. The Employer shall indemnify any employee to whom the Employer has delegated Fiduciary duties against any and all claims, losses, damages, expenses and liabilities arising from their responsibilities in connection with the Plan, unless the same is determined to be due in gross negligence or willful misconduct.

7.5 **Continuation of Medical Benefits**. The Medical Premium, Dental Premium, Vision Premium, Healthcare Reimbursement and Limited Purpose Healthcare Reimbursement Accounts are all deemed to be separate health care benefits under Section 4980B of the Code for purposes of providing continuation health coverage. To the extent any benefits under these Plans may be continued upon the election of a Participant receiving such coverage at the time a "qualifying event" occurs under Section 4980B, any benefits continued shall be provided on an **after-tax** basis and all payments for benefits shall be collected in a manner not to violate the provisions of Section 4980B of the Code.

The Employer shall establish rules to comply with all continuation coverage requirements of COBRA, in accordance with Section 7.5 of the Plan. In addition to such general rules the following rules shall apply for purposes of FMLA and the Services Act:

(a) A "Qualified Beneficiary" who loses health coverage due to a Participant's absence for service in the uniformed services, as defined in the Services Act, may elect to continue such health coverage during the **18** month period beginning on the first day of such absence or, if shorter, during such period as the Participant's right to reemployment is protected by law. A Qualified Beneficiary who elects to continue health coverage under this Section may be required to pay a premium for such coverage. The amount of the premium and the payment schedule shall be determined by the Administrator, in its sole discretion, but in no event shall such premium exceed **102%** of the "applicable premium" for the coverage period.

(b) "Election Period" shall mean a period of at least **60** days duration that begins not later than the date on which the Qualified Beneficiary's coverage under the Plan would otherwise terminate by reason of a Qualifying Event and that ends no earlier than **60** days after the later of: (i) the date such coverage would otherwise end, (ii) the date that the Qualified Beneficiary receives notice of his right to continued coverage under the Plan pursuant to Section 3.6; or (iii) the last day of a leave of absence under the Family and Medical Leave Act of 1993.

(c) "Qualifying Event" for purposes of FMLA shall mean the last day of a FMLA leave of absence, provided the Qualified Beneficiary was covered on the day preceding the first day of such leave (or became covered during such leave) and the Participant fails to return to employment with the Employer at the end of such leave.

(d) A Participant who no longer qualifies for health coverage because of his termination of employment, a reduction in the number of hours that he works or his failure to return from a leave of absence under FMLA may elect COBRA continuation coverage under the Plan pursuant to this Section. A Participant may also elect COBRA continuation coverage for his Dependents who no longer qualify for health coverage. A Participant's Dependents who no longer qualify for coverage in effect under the Plan because of such termination, reduction in hours or failure to return from a leave of absence under FMLA may also elect COBRA continuation coverage pursuant to this Section. COBRA continuation coverage under the Plan may not be elected, however, if the Administrator determines that the Participant was terminated for gross misconduct.

(e) For purposes of all COBRA notices Qualified Beneficiaries must notify the Administrator of a divorce, separation or change in the status of a Dependent child. The Employer must notify the Administrator of the death of an Employee, the termination of an Employee or a reduction in the Employee's hours, if an Employee becomes entitled to Medicare benefits, or an Employee's failure to return from a leave of absence under FMLA. The Administrator must receive such notice from the Employer within **30** days of the event or from the Qualified Beneficiary within **60** days of the event. Within **14** days of its receipt of any notice required by this Section, the Administrator shall notify the Qualified Beneficiary of his right to COBRA continuation coverage under the Plan. Any notification to a spouse or former spouse of a Participant by the Plan Administrator shall also be treated as notification to all other Qualified Beneficiaries residing with said spouse at the time such notification is made.

(f) However, notwithstanding any provisions to the contrary, Healthcare Reimbursement Accounts shall only be permitted to be continued under COBRA until the last day of the Plan Year in which a termination of employment or other similar qualifying event occurs.

7.6 **HIPAA Compliance**. The Medical, Dental, Vision and other health programs, as well as the Regular and Limited Purpose Healthcare Reimbursement Account under certain circumstances shall be treated as a single Health Plan under HIPAA, and all regulations and announcement, as determined within the discretion of the Administrator. The Administrator and the Employer shall comply with all notice and other requirement under HIPAA. A separate HIPAA Notice has been and shall continue to be provided to all Participants in the Flex Plan.

ARTICLE VIII
FIDUCIARY RESPONSIBILITY

8.1 **Fiduciary Duties**. Any Fiduciary shall discharge its duties with respect to the Plan solely in the interest of the Participants and:

(a) For the exclusive purpose of providing benefits to Participants and defraying reasonable expenses of administering the Plan;

(b) With the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

(c) In accordance with the documents and instruments governing the Plan insofar as they are consistent with the provisions of ERISA.

8.2 **Allocation of Responsibility**. Authority and responsibility for management of the Plan shall be allocated among the following persons:

(a) The Employer shall have sole responsibility for the appointment, removal and replacement of the Administrator. To the extent that they are carrying out this responsibility, the members of the Employer shall be "named fiduciaries" of the Plan for purposes of Section 402(a)(1) of ERISA.

(b) The Administrator shall have sole responsibility for the administration of the Plan. To the extent it is carrying out this responsibility, the Administrator shall be a "named fiduciary" with respect to the administration of the Plan.

8.3 **Exclusive Responsibility**. It is the purpose of this Plan to allocate to each of the Fiduciaries identified in Section 8.2 exclusive responsibility for prudent execution of the functions assigned to him (or to the entity of which he is a member) and no responsibility for execution of functions assigned to others. Whenever one such Fiduciary is required by the Plan to follow the directions of another such Fiduciary, the two Fiduciaries shall not be deemed to have been assigned a shared responsibility for the functions assigned to him, including issuing of such directions, and the Fiduciary receiving the directions shall have sole responsibility for the functions assigned to him, including the following of such directions insofar as they are on their face proper under this Plan and under applicable law.

8.4 **Breach of Responsibilities**. A Fiduciary shall not be liable for a breach of fiduciary responsibility by another Fiduciary to whom other fiduciary responsibilities have been assigned under the Plan, except under the following circumstances:

(a) If he participates knowingly in, or knowingly undertakes to conceal, an act or omission of such other Fiduciary, knowing such act or omission is a breach;

(b) If, by his failure properly to discharge his own fiduciary responsibilities, he has enabled such other Fiduciary to commit a breach; or

(c) If he has knowledge of a breach by such other Fiduciary, unless he makes reasonable efforts under the circumstances to remedy the breach.

8.5 **Fiduciary Actions**. In carrying out the responsibilities allocated to him under this Plan, each Fiduciary shall act solely in the interests of the Plan's Participants.

8.6 **Employment of Advisors**. A Fiduciary identified in Section 8.2 may employ one or more persons to render advice with regard to such Fiduciary's responsibilities under the Plan.

ARTICLE IX
CLAIMS

9.1 **Health Benefits**. Claims for the benefits provided under any Health Benefits Plan attached as an Exhibit to this Plan and incorporated herein by reference, shall be made in accordance with the terms and procedures set forth therein.

9.2 **Non-Insured Benefits**. Claims for non-insured benefits shall be made in writing to the Employer, or, in the event the Employer contracts with a person or corporation to process claims for payment from the Medical Reimbursement or Dependent Care Reimbursement Accounts, claims for such benefits shall be forwarded to such person or corporation. Whoever is designated to process claims for non-insured benefits, whether the Employer, or any other person, shall be referred to as the "Claim Coordinator" in this Article IX.

The Claim Coordinator shall make all determinations as to the right of any Claimant to a benefit under the Plan. If the Claim Coordinator denies in whole or in part any claim for a benefit under the Plan the Claim Coordinator shall furnish the Claimant with notice of the decision not later than **30** days after receipt of the claim by the Claim Coordinator, unless otherwise required under Section 9.3 of the Plan or under ERISA, or unless special circumstances require an extension of time for processing the claim as permitted under ERISA. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial **30** day period. In no event shall such extension exceed the period of **15** days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Coordinator expects to render the final decision. If no notice of a decision or extension is provided, the Claimant shall assume the claim has been denied.

Although Dependent Care Accounts are neither subject to ERISA or the new Department of Labor Claims Procedures, all provisions of Article IX shall apply to Dependent Care Reimbursement Accounts to avoid the need to maintain two separate Claims Procedures.

9.3 **Post-Service and Other Procedures**. The Claims Procedures for Post-Service Claims and other claims shall be as follows:

a. **Post-Service and Other Claims**. In the case of a Post-Service Claim, and any other claims for benefits under the Plan, the following timetable shall apply:

i. Notification to Claimant of benefit determination shall be made within **30** days.

ii. Extensions due to matters beyond the control of the Plan shall be up to **15** days.

iii. Extensions due to insufficient information shall be up to **15** days.

iv. Responses by a Claimant following notice of insufficient information shall be made within **45** days.

v. Review of adverse benefit determinations shall be made within **60** days of a request for reconsideration.

This Plan does not provide for **2** levels of appeal. Thus, the review of adverse benefit determination is not required to be a period of **15** days per benefit level of appeal.

b. **Notice of Claimant of Adverse Benefit Determinations**. Except with Urgent Care Claims that do not apply to this Plan (when the notification may be oral followed by written or electronic notification within **3** days of the oral notification), the Claims Coordinator shall provide written or electronic notification of any adverse benefit determination. The notice shall be issued in accordance with the above timetable and shall state, in a manner calculated to be understood by the Claimant:

i. The specific reason or reasons for the adverse determination.

ii. Reference to the specific Plan provisions on which the determination was based.

iii. A description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary.

iv. A description of this Plan's review procedures, incorporating any voluntary appeal procedures offered by this Plan, and the time limits applicable to such procedures. This shall include a statement of the Claimant's right to bring a civil action under Section 502 of ERISA following an adverse benefit determination on review.

v. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. **A Claimant may have other voluntary alternative dispute resolution options, such as mediation. To find out what alternatives are available a claimant may contact the local U.S. Department of Labor Office**.

vi. If an adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion shall be provided free of charge. If this is not practical, a statement shall be included that such a rule,

guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy shall be provided free of charge to the Claimant upon request.

vii. If the adverse benefit determination is based on the medical necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of this Plan to the Claimant's medical circumstances, shall be provided. If this is not practical, a statement shall be included that such explanation shall be provided free of charge, upon request.

9.4 **Appeals**. When a Claimant receives an adverse benefit determination, the Claimant or an authorized representative has **180** days following receipt of the notification in which to appeal the decision to the Appeals Committee. The Appeals Committee shall be established by the Employer as the "Named Appeals Fiduciary", as required under ERISA for reviewing claims. A Claimant may submit written comments, documents, records, and other information relating to the Claim. If the Claimant so requests, he or she shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

i. Was relied upon in making the benefit determination;

ii. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

iii. Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provision have been applied consistently with respect to all Claimants; or

iv. Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit

determination. The review shall not afford deference to the initial adverse benefit determination and shall be conducted by a fiduciary of this Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Appeals Committee shall consult with a health care professional who was not involved in the original benefit determination. This health care professional shall have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of this Plan in connection with the initial determination shall be identified.

The Appeals Committee shall make its decision on review not later than **60** days after receipt by the Appeals Committee of the claimant's request for review (**30** days if the Plan provides for two levels of review, which is not applicable to this Plan). The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated, to be understood by the Claimant, and specific references to the pertinent Plan provisions on which the decision is based, in the same manner as provided in Section 9.3(b)

9.5 **Compliance with Regulations**. It is intended that the claims procedure of this Plan be administered in accordance with the claims procedure regulations of the Department of Labor set forth in 29 CFR §2560.503-1. To the extent the above provisions are determined to be inconsistent with the regulations, the DOL regulations shall be controlling.

ARTICLE X
MISCELLANEOUS

10.1 **Insurance Contracts**. Some or all of the benefits provided under the Plan are provided by the purchase of one or more insurance contracts. Any dividends or retroactive rate or other refunds, which may become payable under any insurance contracts or benefit programs due to actuarial error in rate calculation, or favorable claims experience, shall be the property of and shall be retained by the Employer, within its discretion, or applied to pay any expense associated with the administration of the Plan.

10.2 **Benefit Costs**. The Employee cost of each Nontaxable Benefit shall be determined by the Employer. Nothing contained in this Plan shall preclude the Employer from increasing the Employee cost of any Nontaxable Benefit, to the extent Employees are not required to pay the full cost of such Nontaxable Benefit.

10.3 **Annual Statement**. The Administrator shall provide each Participant with a written statement explaining the amounts paid or expenses incurred by the Employer in providing any dependent care assistance, if applicable, as required under Section 129(c)(7) of the Code on or before each January 31. The Annual Form W-2 may be used to satisfy this requirement.

10.4 **Services to the Plan**. The Employer may contract for legal, actuarial, investment advisory, medical accounting, clerical and other services to carry out the Plan. The costs of such services and other administrative expenses under the Plan and shall be paid by the Employer except as otherwise permitted.

10.5 **Heroes Earnings Assistance and Relief Tax Act ("HEART") of 2008**. On June 17, 2008, the Heroes Earnings Assistance and Relief Tax Act of 2008 (also known as the Heroes or "HEART" Act) was enacted. The Act made several changes to the Code for members of the military and their families. One provision of the Act amended Section 125 of the Code to allow a "Qualified Reservist Distribution" from the Medical FSA of a participant who is a reservist called to active duty for at least **180** days (or for an indefinite period). Amounts withdrawn as a Qualified Reservist Distribution are **not subject** to the "use it or lose it" rule. This change is applicable to distributions made after the date of enactment (i.e., June 17, 2008). The Employer has elected **to adopt** the Heart Act provisions for "Qualified Reservist Distributions".

10.6 **Amendment and Termination**. The Employer may amend, modify, or terminate this Plan at any time by action of an officer of the Employer. No amendment shall deprive any Participant or beneficiary of any Nontaxable Benefit to which he is entitled under this Plan with respect to contributions previously made, and no amendment shall provide for the use of funds or assets other than for the benefit of Employees and their beneficiaries, except as may be specifically authorized by statue or regulation.

Effective as of June 12, 2008, the Plan Administrator may amend the Plan at any time to the extent the Plan Administrator determines such amendment is necessary or desirable and does not increase the costs of the Plan to the Company or a Participating Company by more than **$250,000** on an annual basis, as determined by the Plan Administrator and to the extent permitted by applicable law.

10.7 **Proof of Claim**. As a condition of receiving benefits under the Plan, any person may be required to submit whatever proof the Employer may require (either directly to the Administrator or to any person delegated by it).

10.8 **Status of Benefits**. The Employer believes that this Plan is in compliance with Section 125 of the Code and that it provides certain benefits to Employees which are tax free pursuant to other provisions of the Code. This Plan has not been submitted to the Internal Revenue Service for approval and thus there can be and is no assurance that intended tax benefits shall be available. Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan shall be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment shall apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

10.9 **Taxation of Domestic and Civil Union Partners**. Domestic and Civil Union Partners are not treated as Spouses or other family members under the Code. Accordingly, a Participant **may not use** the Regular or Limited Purpose Healthcare Reimbursement Account to obtain reimbursement for healthcare expenses incurred by a Domestic or Civil Union Partner. Furthermore, to the extent a Participant elects medical coverage for a Domestic or Civil Union Partner, and pays for any portion of the Participants' cost of such coverage, such costs shall be paid with **after-tax** dollars. To the extent that the Employer pays any portion of the cost of medical coverage for a Domestic or Civil Union Partner, the cost of such coverage shall be included in the Participant's income.

10.10 **Retroactive Changes** . Election changes from Salary Reduction Contributions may only be made on a prospective basis, except for retroactive enrollment rights under Section 9801(f) of the Code that applies in case of an election made within **31** days of a birth, adoption, or placement for adoption of a child.

10.11 **Nondiscrimination Rules** . Under HIPAA, certain nondiscrimination and other rules shall generally apply to the Plan effective as of April 14, 2001, unless a later effective date is established. These rules are intended to avoid nondiscrimination with regard to medical benefits available to employees. To the extent that the HIPAA nondiscrimination rules apply to a Section 125 Plan, the Employer shall take such rules into consideration.

10.12 **Omitted Provisions**. To the extent any provisions of the 2000 or 2001 Regulations have been inadvertently omitted from this Amendment, such provisions are hereinafter incorporated into this Amendment by reference. Furthermore, to the extent the IRS issues any further announcements and/or clarifications regarding Section 125 Plans, the Plan Administrator shall have the right to follow such rules regardless of whether or not the Plan is amended for such provisions, and such provisions shall be incorporated into the Plan by reference.

10.13 **Lost Distributees**. Any benefit payable hereunder shall be deemed forfeited if the Employer is unable to locate the Participant to whom payment is due, provided, however, that such benefit shall be reinstated if a claim is made by the Participant for the forfeited benefit.

10.14 **Heirs and Assigns**. This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each Participant and beneficiary.

10.15 **No Contract of Employment**. The establishment and maintenance of the Plan shall not constitute a contract of employment or confer upon any Employee the right to continue in employment with the Employer or Participating Employer and the Employer or Participating Employer reserves the right to terminate the employment of any Employee whenever the interest of the Employer or Participating Employer, in their sole judgment, may require such action.

10.16 **Reimbursements**. The Administrator shall have complete discretion to conform any reimbursement practices contained herein with the existing accounting practices of the Employer or any Participating Employer to the extent reimbursements are not delayed beyond a reasonable period of time.

10.17 **Information to be Furnished**. Participants shall provide the Employer and/or Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administering the Plan.

10.18 **Incapacity**. If the Employer or Participating Employer deems any person to be incapable of receiving any benefits by reason of illness, infirmity or other incapacity established by medical evidence or because such person is a minor, it may direct that payment be made directly for the benefit of such person or to a legal guardian of the person. To the extent payments are made in this manner, the Employer or Participating Employer shall be discharged from all liability with regard to such payments.

10.19 **Continuation by a Successor**. In the event of a dissolution, merger, consolidation or reorganization of the Employer, provision may be made under which the Plan shall be continued by the successor to the Employer; and, in that event, such successor shall be substituted for the Employer under the Plan. The substitution of the successor shall constitute an assumption of Plan liabilities by the successor and the successor shall have all of the powers, duties, and responsibilities of the Employer to which it succeeds under the Plan. Contributions by the Employer shall be automatically suspended from the effective date of any such reorganization until the date upon which the substitution of such successor corporation for the

Employer under this Plan becomes effective. If, within **90** days following the effective date of any such reorganization, the successor corporation shall not have elected to become a party to this Plan, or if the Employer shall adopt a plan of complete liquidation other than in connection with a reorganization, this Plan shall be automatically terminated as of the close of business on the **31st** day following the effective date of such reorganization or as of the close of business on the date of adoption of such plan of complete liquidation, as the case may be.

10.20 **Nonalienation of Benefits**. Except as otherwise provided by law and by any contract governing any benefit offered under this Plan, no benefit under the Pan may be voluntarily or involuntarily assigned or alienated.

10.21 **Medical Child Support Orders**. In the event the Administrator receives a medical child support order regarding any benefits under the Plan (within the meaning of Section 609(a)(2)(B) of ERISA), the Administrator shall notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of Section 609(a)(2)(A) of ERISA). Within a reasonable period the Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

10.22 **Coordination of Benefits**. Medical, dental and vision benefits shall be coordinated between plans, or within this Plan, in accordance with the following provisions, to the extent not inconsistent with the provisions of any applicable contracts to provide medical coverage, in which case the provisions of any underlying medical plan or insurance contracts shall be controlling.

Benefits provided under this Plan shall be paid in full when this Plan is the primary plan. When this Plan is the secondary plan, this Plan shall provide a benefit so that the combined benefits under both plans (including all benefits that would have been paid had timely claim been filed with the plan) shall not exceed the amount which would have been paid under this Plan if there were no other plan involved. The Administrator is authorized to establish reasonable procedures to administer COB issues using either the “birthday” or the “gender” rules, as it determines, within its discretion.

Furthermore, the Plan shall have the right of recovery in third-party actions, determined in accordance with reasonable procedures established by the Administrator, to the extent not inconsistent with the provisions of any insurance contracts, in which case the provisions of the insurance contracts shall control.

The Plan shall also comply with the provisions of Section 609(b) of ERISA as follows.

(a) The payment of benefits with respect to a Participant shall be made in accordance with any assignment of rights made by or on behalf of such Participant or a Dependent of such a Participant under the Medicaid laws of any state;

(b) The enrollment of and provision of benefits to a Participant shall be made without regard to the Participant's eligibility for Medicaid under the laws of any state; and

(c) To the extent that payment has been made under the Medicaid laws of any state in a case where the Plan has legal liability for such payments, payment of benefits under the Plan shall be made in accordance with any state law which provides that such state has acquired the rights of the Participant or a Dependent of such Participant to such payment.

10.23 **Future Changes**. Inframark acknowledges that Proposed Regulations have been issued by the IRS under Section 125 of the Code. When the regulations become final, it is anticipated that the Flex Plan shall be amended and restated to comply with the Final Regulations.

10.24 **Service of Legal Process**. The name and address of the person(s) designated as the agent for service for legal process for the Plan is:

Employee Benefits Committee:
Inframark, LLC
220 Gibraltar Road, Suite 200
Horsham, PA 19044

10.25 **No Taxation of Children Coverage Up to Age 27**. Although Children health coverage must be provided up to age **26**, in accordance with IRS Notice 2010-38, the income tax exclusion for health coverage for Children applies for children under age **27** as of the end of any calendar year, effective as of March 30, 2010.

10.26 **Severability**. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

10.27 **Gender and Number**. Except where otherwise required by the context, any words used in the masculine gender shall be construed to include the feminine gender or vice versa. Also, where appropriate, any word used in the singular shall be construed to include the plural and vice versa.

10.28 **Headings**. Any headings preceding the texts of the several Articles and Sections of this Plan are inserted solely for convenience of reference and shall not affect its meaning, construction or effect.

10.29 **Governing Law**. The Plan shall be construed and enforced according to the laws the Commonwealth of Pennsylvania, except to the extent such laws have been preempted by ERISA, or any other federal law.

This Plan is effective as of January 1, 2023, as reflected above.

EMPLOYER:

INFRAMARK, LLC

By:_____

EXHIBIT A

NONTAXABLE BENEFITS

A Participant under this Plan may elect to participate in the benefit plans maintained by the Employer that provide the following benefits:

Health Insurance Coverage
(including prescription drugs coverage)

Dental Insurance Coverage

Vision Insurance Coverage

Regular Health Care Reimbursement Coverage

Limited Purpose Healthcare Reimbursement Coverage

Health Savings Account ("HSA") Coverage

Dependent Care Spending Account

Accidental Death and Dismemberment Coverage ("AD&D")

Long-Term Disability

AFTER-TAX BENEFITS
(Paid with After-Tax Dollars Outside the Flex Plan)

Supplemental Employee Life Insurance Coverage

Dependent Life Insurance Coverage

Long-Term Disability

January, 2023

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