SUMMARY PLAN DESCRIPTION

FOR THE

INFRAMARK FLEXIBLE BENEFITS AND WELFARE BENEFIT PLANS

THE PLAN AS OUTLINED IN THIS SUMMARY PLAN DESCRIPTION IS GOVERNED IN EVERY RESPECT BY THE WORDING OF THE ACTUAL PLAN DOCUMENT WHICH IS AVAILABLE FOR INSPECTION BY ALL PLAN PARTICIPANTS. IN THE EVENT OF ANY CONFLICT IN MEANING, THE PLAN WILL PREVAIL. THE PLAN IS SUBJECT TO CHANGE. ANY CHANGES WHICH MATERIALLY CHANGE THE PROVISIONS OF THIS SUMMARY WILL BE COMMUNICATED TO YOU.

November, 2018

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Introduction

Inframark, LLC ("Inframark" or the "Company"), maintains the Inframark Flexible Benefits Plan (the "Plan" or the "Flex Plan") to allow eligible employees to elect to reduce their salaries to pay for the employee cost of healthcare, dental, vision and other coverages on a **pre-tax** basis. You are also allowed to elect to make **pre-tax** contributions to Healthcare Flexible Spending Account (a "Full FSA"), a Limited Purpose Health FSA (a "Limited FSAs"), Health Savings Accounts ("HSAs") and Dependent Care Reimbursement Accounts ("Dependent Care Accounts"). You also have the ability to elect to **cash-out** vacation or paid time off, or to **purchase** additional vacation days. Participation in the Flex Plan is completely **voluntary**. Affiliates of Inframark participate in the Inframark Flex Plan. The purpose of this document is to help you to determine if participation in the Flex Plan is beneficial to you and your family.

This document provides a summary of the provisions of the Flex Plan and various health and welfare benefit programs. This document is designed to answer your questions in clear and understandable language. It explains who runs the Flex Plan, how the Flex Plan is structured, what benefits are available under the Flex Plan, and what rights and obligations you have under the Flex Plan. However, this document is only intended as a summary and is known as a Summary Plan Description ("SPD") for various welfare benefit plans. The Flex Plan is administered in accordance with a Flex Plan document which is available for inspection. If any conflict exists between this Summary and the Flex Plan or any underlying plan documents, the Flex Plan or other applicable documents will be controlling. You should not make any decisions with respect to your rights and obligations under the Flex Plan unless you fully understand the consequences of all such decisions for yourself and your family. Remember, the Flex Plan and all benefit programs are maintained and operated for the exclusive benefit of you and your family.

Summary of Important Plan Provisions

Who is eligible to participate in the Flex Plan?

You are generally eligible to participate in the Flex Plan upon the first day of the **month** after your **date of hire** within the Inframark controlled group provided, however, that you are regularly scheduled to work at least **30** hours per week and the eligibility requirements of any underlying health, dental or other Welfare Plans are satisfied.

What benefits are available under the Flex Plan?

You may elect to:

- **Make pre-tax** contributions to pay for the employee cost of health and prescription drug coverage and under the:
  - Self-Insured Basic Health Plan administered by United Healthcare ("UHC")

- Self-Insured Standard Health Plan administered by UHC
- Self-Insured Premium Health Plan administered by UHC
- Several Out of Area Network Health Plans also exist for certain geographic areas
- Self-Insured High Deductible Health Plan ("HDHP") administered by UHC
- Other Health Plans identified in **Exhibit A**. See **Exhibit B** for additional information regarding all health programs.

Prescription Drug coverage is provided under a self-insured Plan administered by Express Scripts, for all of the above Health Plans.

- **Make pre-tax** contributions to a Health Savings Account ("HSA") with Optum if you participate in the HDHP.

- **Make pre-tax** contributions to a self-insured Dental Plan administered by MetLife.

- **Make pre-tax** contributions to the fully-insured VSP Vision Plan.

- **Make pre-tax** contributions up to **$2,700** in 2019 to a Full FSA to obtain reimbursement for health expenses which are not covered under any health plans, such as deductibles and co-insurance requirements, **excluding** over-the-counter drugs (unless coverage is for insulin or with a prescription). The Full FSA is only available to employees who **do not elect** the HDHP. Up to **$500** may be rolled over, if not spent during the 2019 calendar year, into the 2020 calendar year.

- **Make pre-tax** contributions to a Limited FSA to pay for only unreimbursed **dental** and **vision** coverage if you participate in the HDHP and contribute to an HSA.

- **Make pre-tax** contributions to a Dependent Care FSA to pay for eligible dependent daycare expenses (for children up to age **13** or eligible adults). Please do **not** elect the Dependent Care FSA unless you have dependent children for whom you will incur dependent care costs to work. The Dependent Care FSA may **not be used** for dependent healthcare expenses.

- **Receive after-tax** Long-Term Disability ("LTD") coverage unless you elect to obtain this benefit on a pre-tax basis by opting out of the default **after-tax** alternative.

- **Make after-tax** contributions to purchase life insurance and other supplemental benefits.

- **Cash-out** certain Vacation Time or **purchase** additional Vacation/PTO Time.

- Please note that for claims incurred during 2018, employees should have a **2½** month grace period to submit expenses for reimbursement. This is not the old "grace period" in effect prior to the **$500** rollover rule. If amounts are not reimbursed within the grace

period, then the **$500** rollover rule to a Full Flexible Spending Account ("FSA") or a Limited Purchase FSA becomes effective. **[It would be helpful to confirm that these are the procedures being followed by Vantagen, the recordkeeper for the Flex Plan.]**

Are there any after-tax benefits available under the Flex Plan?

Yes. You may elect to purchase certain life insurance, including life insurance for your spouse and dependents, using **after-tax** dollars. These benefits are purchased using election forms during the open enrollment process. Please note that different rules may apply to **pre-tax** and **after-tax** benefits in the event you wish to make a benefit election change.

When may I elect to become a Participant in the Flex Plan?

To participate in the Flex Plan you must complete the **on-line** Flexible Benefits Enrollment Forms. Forms are generally completed on-line during the Open Enrollment Period each **October/November**, which is in advance of the first day of each Plan Year beginning on **January 1**. If you do not complete the enrollment process in the Flex Plan when first eligible to do so, you will **not receive** health, dental or other coverages, except for certain basic life insurance and disability coverage.

If you are first employed by Inframark or any Affiliate after the beginning of a Plan Year, you may enroll in the Flex Plan by completing the appropriate **on-line** Forms within **30** days after you become eligible to participate in any health, dental, vision or other benefit programs.

If you do not elect to participate in the Flex Plan when you are first eligible to do so, you must generally wait until the next Open Enrollment Period which is during the months of October/November to elect to participate in the Flex Plan. For example, if you are hired and become eligible to participate in the Flex Plan in **May, 2019**, but decline participation in the Flex Plan, you will generally (unless you have a qualifying life event) be able to enroll in the Flex Plan during the Open Enrollment Period during **October/November, 2019**, and will begin participating in the Flex Plan for the Plan Year beginning **January 1, 2020**.

If I do not make an election, are there any default elections?

Generally No. If you do not elect health coverage, you are not defaulted into any health or dental coverage. You will receive STD coverage and basic LTD coverage. You will also receive a Life Insurance benefit equal to **1** times your base salary up to a maximum benefit of **$200,000** and participation in the Employee Assistance Plan. These rules only apply if you never enrolled in any Health Plans. Otherwise, prior elections will "rollover" each year except for the Full FSAs, the Limited FSAs, the HSA or the Dependent Care Reimbursement Account, on the vacation cash-out provisions, all of which require active annual elections. Please note that you will receive LTD coverage on an **after-tax** basis if no elections are made by you.

May I enroll my spouse, domestic partner or civil union partner in the Health Plans and other programs?

Yes. A spouse, domestic partner or civil union partner may be enrolled in most Welfare Plans. The tax consequences associated with such action are described below.

A same-sex spouse, as recognized under Federal law, is a spouse for purposes of the Welfare Benefit Plans. Therefore, if you are married in a state or foreign country that recognizes a same-sex spouse relationship, you are married (i.e., under the **"state of celebration"** rule), even if a same-sex relationship is not recognized in your state of residency. However, different state income taxes may exist depending upon the status of same-sex spouses in certain states.

How are my contributions used under the Flex Plan?

All employee contributions will be used to pay for benefits as follows:

- Healthcare and Prescription Drug Premium Contribution.
- Dental Premium Contribution.
- Vision Premium Contribution.
- Full FSA.
- Limited FSA – beginning in 2015.
- Health Savings Account ("HSA") with Optum if you elect the HDHP.
- Dependent Care Reimbursement Contribution.
- Additional Vacation/PTO Time.
- All employee contributions are forwarded to the applicable company or entity to obtain life, disability or other insurance coverages.

Must I take any actions to "waive" health or other coverages?

No. If you do not wish to receive and pay for health coverage since you have access to other health coverage, you should simply complete the on-line processes reflecting you do not wish to accept health coverage. Please note that under the Affordable Care Act ("ACA") most individuals were required prior to 2019 to maintain health insurance. This ACA "personal" mandate is **eliminated** in 2019. Thus, if you "waive" health coverage and do not have health insurance available elsewhere, through a spouse, parent or partner, you **will no longer be**

subject to penalties under ACA.

If I do not elect health or dental coverage, may I later elect to receive such coverage if the other coverage I have for myself and/or my family is lost?

Yes. You may elect coverage during the next Open Enrollment Period. In the event of certain life events, such as a loss of employment of a spouse, or if the coverage is drastically decreased, you may also elect to receive coverage mid-year. This change occurs outside of the Open Enrollment Period.

How do I elect to reduce my salary to pay for eligible expenses on a pre-tax basis?

When you are eligible to participate in the Flex Plan, you may use the **on-line** enrollment process to designate the portion of your salary, if any, you wish to contribute to the Flex Plan to pay for eligible benefits. For purpose of the Flex Plan your salary will mean your base compensation.

What type of dental coverage may I elect?

You may elect the Dental Plan with MetLife. You pay your portion of the cost of dental coverage with **pre-tax** basis.

Can I obtain vision coverage?

Yes. An insured Voluntary Vision Plan is maintained with VSP Vision. You may pay for the full cost of vision coverage with **pre-tax** dollars.

How are Employee Contributions for health, dental and vision benefits treated?

If you elect to receive either health, dental or vision coverages, you will pay the employee cost for health, dental or vision benefits with **pre-tax** dollars. You will be required to complete an on-line Form which will permit Inframark to reduce your compensation in an amount necessary to pay your contribution for such coverage. All amounts withheld from your compensation will be paid to the appropriate insurance carrier or third party administrator within **30** days after being withheld from your compensation. In the event your employee contribution or compensation changes, the amount to be withheld for healthcare, dental or vision coverage, **may be automatically adjusted** in accordance with the terms of your Salary Reduction Election Form.

How do I make pre-tax Salary Reduction Contributions for Non-Covered Healthcare Expenses?

Not all healthcare expenses are completely reimbursed by the healthcare programs maintained by Inframark. You therefore pay for unreimbursed expenses such as deductible and

co-insurance requirements with **after-tax** dollars. In addition, some expenses such as orthodontia, office visits, co-pays, and additional glass lenses may not be covered by your healthcare programs. The Flex Plan permits you to reduce your salary up to **$2,700** to make a contribution to a Full FSA each Plan Year. The minimum contribution to the Full FSA in any Plan Year is **$130** per year (i.e., **$5** per **26** payroll periods). Contributions to the Full FSA are made on a **pre-tax** basis. If you enter the Plan during any Plan Year, the **$2,700** maximum is **not prorated**. For example, if you enter the Plan on July 1, you will be able to contribute the full **$2,700** maximum amount to the Full FSA during the last **6** months of the Plan Year. All amounts to be contributed to your Full FSA will be available to pay healthcare, dental or other expenses which are not reimbursed under any employer or other healthcare programs. Expenses for over-the-counter drugs, such as antacids, allergy medicine, pain relievers, cold medicine and other drugs may only be reimbursed if prescribed by a physician or for insulin.

A list of Eligible Full FSA Expenses is identified in **Exhibit C**. Any contributions allocated to your Full FSA which are not applied to reimburse you for expenses incurred during the Plan Year, or within a **2½** month **"grace period"** after the end of the 2019 Plan Year (to submit expenses incurred in 2019), **will be forfeited**. Please note that any funds left in your Full FSA, up to **$500**, will be "carried over" to the next calendar year (i.e., 2020 for Full FSA funds as of December 31, 2019), if not vested to reimburse you for expenses incurred in 2019. **[To confirm this is consistent with actual administrative procedures.]**

How do I make pre-tax Salary Reduction Contributions to the Limited FSA?

You may elect to make contributions to a Limited FSA in the same manner as the Full FSA Account, up to the **$2,700** limit. If you participate in the HDHP and maintain an HSA, you may **only use** the Limited FSA to obtain reimbursement for **dental** and **vision** expenses. If you elect to participate in the HDHP in 2019 and have up to **$500** of unused funds in your Full FSA as of December 31, 2018, such amount will **automatically** rollover to a Limited FSA in 2019.

How do I elect to make pre-tax contributions to an HSA if I participate in the HDHP?

The **on-line** enrollment process will permit you to contribute up to the maximum annual limitations to HSAs based upon your family status. You may generally contribute **$3,450** to the HSA in 2018 (**$3,500** in 2019) if you are single, and **$6,900** in 2018 (**$7,000** in 2019) to the HSA if you have family status. Furthermore, if you are age **55** and older, you may contribute an additional **$1,000** each year. See **Exhibit D** for more information.

Please remember, if you elect the HDHP you may **not participate** in the Full FSA or any other health plan, including Medicare. However, you will be eligible to make contributions to a Limited FSA for **dental** and **vision expenses**.

What contributions will Inframark make to my HSA, if I elect the HDHP?

Inframark will make the following contributions to an HSA if you elect the UHC HDHP:

Status	**Inframark Contributions**
Individual:	**$500** annual contribution made on the first day of each Plan Year.
Family:	**$1,000** annual contribution made on the first day of each Plan Year.

Once Inframark Contributions are transferred to your HSA, such funds belong to you.

If you are hired during the calendar year, you will receive the entire Inframark Contribution to your HSA and such contribution is **not pro-rated** for partial years.

If you do not spend all of the contributions made to your HSA on an annual basis, funds **remain in your HSA** from year to year and are **not lost** under the "use it or lose it" rules that apply to the Full or Limited FSAs (subject to the new **$500** rollover rule).

How do I make withdrawals from my HSA with Optum?

Withdrawals from your HSA are limited to your HSA account balance with Optum. **[To confirm.]** Funds for eligible medical expenses may be accessed by:

- Using your HealthHub Debit Card for HSA expenses at qualified merchants. Please be sure to read the separate communication explaining the special rules and requirements that apply to your card.

- Transfer funds on-line to reimburse yourself or to directly pay vendors.

Regardless of how funds from your HSA are accessed, you are responsible for maintaining all documentation and receipts to prove that funds from your HSA were used for eligible medical expenses.

How does the "Vacation/PTO Cash-Out" benefit work?

You may elect to waive your entitlement up to **3** days of Vacation/PTO Time (i.e., **24** hours) and receive **50%** of the value of such days in cash. The value of your cash-out to be transferred to your Vacation Account will be based upon your compensation at the end of 2018 (i.e., salary increases during 2019 will not change the amount allocated to your vacation account). If you remain employed through the entire 2019 calendar year, the Vacation Cash-Out will be paid to you in December, 2019, or earlier, upon a separation from service. **[To confirm this is consistent with the intended administrative procedures for Inframark. These procedures are recommended by P&E to avoid taxation to employees until payment is made.]**

In the event that you terminate employment prior to the end of the 2019 calendar year, an immediate payment of the amount in your Vacation Account will be paid in cash if this option is elected and Vacation/PTO Time has not actually been used prior to such termination.

How does the Vacation/PTO Time Purchase benefit work?

You may elect to purchase additional Vacation/PTO Time and to receive additional time off up to **40** hours of Vacation/PTO Time. You may elect to purchase Vacation/PTO Time in one hour increments based upon the value of such benefits at the time of deferral prior to the beginning of each Plan Year. If you terminate employment prior to the end of any Plan Year, a cash-out of Vacation/PTO Time will occur in the same manner as any other Vacation/PTO Time to which you are entitled.

How do I elect to make contributions to pay for Dependent Care Expenses?

To help employees pay for dependent care expenses, Inframark has established a Dependent Care Assistance Plan under the Flex Plan. The Flex Plan permits you to reduce your salary to contribute to a Dependent Care Reimbursement Account. Amounts held in your Dependent Care Reimbursement Account will be used to reimburse you for Eligible Dependent Care Expenses.

You may reduce your salary up to **$5,000** to contribute to the Dependent Care Reimbursement Account in each calendar year. The minimum contribution is **$130** per year (i.e., **$5** per **26** pay periods). The election for the Dependent Care Reimbursement Account is made each **October/November** for the following calendar year. Contributions to the Dependent Care Reimbursement Account are made on a **pre-tax** basis. This is the maximum amount of Eligible Dependent Care Expenses which may be reimbursed each calendar year without incurring Federal income taxes. If you are married and file a separate Federal income tax return from your spouse, only **$2,500** may be excluded from your Federal taxable income. It is therefore important to consider your marital status for filing purposes when electing to reduce your salary to contribute to your Dependent Care Reimbursement Account. Any contributions allocated to your Dependent Care Reimbursement Account which are not applied to reimburse you for expenses incurred during the Plan Year **will be forfeited**.

What are Eligible Dependent Care Expenses?

Child and dependent care expenses such as day care and babysitting fees must be **work-related** to qualify for the reimbursement from your Dependent Care Reimbursement Account, or to be entitled to use the Child Care Credit discussed below. Expenses are considered work-related **only if** they allow you (and your spouse, if you are married) to work. In certain situations, however, your spouse does not have to work if he or she is a student-spouse or is unable to care for himself or herself.

Whether you incur expenses to allow you to work depends on many factors. Expenses are not considered work-related merely because you incurred them while you work. Work-related expenses include expenses for household services, and the care of a qualifying person. Qualifying persons include dependents under age **13**, or a dependent or spouse who is physically or mentally incapable of caring for himself or herself. In no event, however, are expenses for an overnight camp ever considered to be eligible. A more detailed list of eligible expenses and requirements are identified in **Exhibit E** to this SPD.

Are there any other limits on the amount of Eligible Dependent Care Expenses which may be reimbursed without incurring Federal income tax?

Yes. The favorable tax treatment provided for Dependent Plans is available to provide a tax break to parents who incur child care expenses in order to be gainfully employed. Additional limits do, however, exist to receive this beneficial tax status. In addition to the **$5,000** and **$2,500** maximum annual reimbursement limits, eligible child care expenses may not exceed:

Single Employees

Your Earned Income for the year if you are single at the end of the calendar year.

Married Employees

The smaller of your Earned Income or the Earned Income of your spouse, if you are married at the end of the calendar year. If your spouse is a full-time student or unable to care for himself or herself, your spouse will generally be considered to have an Earned Income of **$250** per month if there is one qualifying person in your home, or **$500** per month if there are two or more qualifying persons. For purposes of these rules "Earned Income" generally includes wages, salaries, tips, other employee compensation and net-earnings from self-employment.

Do I have to take any action to ensure I do not pay Federal income taxes on dependent care expenses for which I receive reimbursement under the Plan?

Yes. The Federal tax exclusion for dependent care expenses is not available unless you, the taxpayer, report the dependent care provider's correct name, address and taxpayer identification number on your Federal income tax return, or you can substantiate that you exercised due diligence in attempting to provide this required information. You are encouraged to obtain the tax identification number for any service provider **in advance** of receiving any dependent care services.

Is it more beneficial for me to pay for child care expenses with a Dependent Care Reimbursement Account or to use the Child Care Credit permitted under the Internal Revenue Code?

This question must be answered on an individual basis and Inframark encourages you to review this decision with your tax advisor. To assist in this determination the Child Care Credit will be briefly explained. Please realize this is only a general explanation and the tax rules are subject to change.

It is very important for you to consider all tax rules, including any changes, in determining if the Child Care Credit or the Dependent Care Reimbursement Account is most beneficial to you.

Inframark strongly **encourages** you to review the Child Care Credit with **your own tax advisor** prior to electing to reduce your salary to contribute to a Dependent Care Reimbursement Account.

What other benefits are available under the Flex Plan or any Welfare Benefit Plan?

No other **pre-tax** benefits exist under the Flex Plan (other than LTD coverage below). However, you are provided and may elect to purchase the following benefits with **after-tax** dollars outside of the scope of the Flex Plan:

- **Employee Assistance Plan ("EAP")**. Inframark provides an EAP with Health Advocate for all employees and their families, regardless of actual hours worked, to obtain access to behavioral care professionals at **no cost**. This coverage is available **24** hours a day, **7** days a week through a toll-free number, (866) 799-2691. See **Exhibit F**.

- **Group-Term Life Insurance**. All employees regularly scheduled to work **30** or more hours per week receive group-term life insurance **100%** paid by Inframark equal to **1** times base salary, with a maximum benefit of **$200,000** at **no cost**. Only the first **$50,000** of life insurance can be provided tax-free. The cost of Inframark paid life insurance coverage, and any insurance you purchase above **$50,000**, may only be paid with **after-tax** dollars, or is imputed into (included in) your income.

  See **Exhibit G.**

- **Supplemental Employee Life Insurance**. You may elect to purchase additional life insurance equal to **1**, **2**, **3**, **4** and **5** times annual base salary up to a maximum of **$500,000**.

- **Voluntary Dependent Life Insurance**. All full-time employees and part-time employees working a minimum of **30** hours per week are entitled to purchase life insurance for spouses/domestic partners and/or children with **after-tax** dollars upon approval of coverage by Prudential.

  The benefits for life insurance are equal to:

Spouse/Domestic Partner	Children (up to age 26 generally)
$20,000	**$2,500**
$30,000	**$5,000**
$40,000	**$10,000**
$50,000	

  You may purchase up to **$20,000** of insurance for spouse/domestic partner without evidence of insurability. Proof of good health is required if you elect the **$50,000** spousal/domestic partner life insurance option. If you do not elect life insurance when first eligible, proof of good health is also required.

  Dependent children are covered up to age **26**.

  See **Exhibit H**.

- **Personal Accident Insurance ("Accidental Death and Dismemberment – AD&D Coverage")**. Inframark provides AD&D coverage to all employees regularly scheduled to work **30** or more hours per week, at **no cost**. This benefit provides coverage equal to **1**times your basic salary up to **$200,000**.

  See **Exhibit I** for additional information.

- **Short-Term Disability**. Inframark provides short-term disability coverage to all employees regularly scheduled to work **30** or more hours per week at **no cost** after a **90** day waiting period, which includes a **14** day period of illness or injury. This benefit varies between **65%** and **80%** of your salary, based upon your years of service with Inframark. For example, employees with less than **5** years of service receive a benefit equal to **65%** of their monthly wages, while employees with **5** or more years of service receive **80%** of their monthly earnings at the time of disability. Disability benefits are provided up to **90** days (after the **90** day waiting period, including the **14** day period of illness or injury), or until an individual returns to work, whichever is earlier. This benefit is self-insured by Inframark.

  See **Exhibit J**.

- **Long-Term Disability**. Inframark provides Long-Term Disability ("LTD") coverage to all employees regularly scheduled to work **30** or more hours per week on the first day of employment, with Prudential. Benefits generally begin after **3** months of disability, after STD benefits cease to be paid. The maximum benefit is **$10,000** per month, with certain offsets for other coverage. Inframark pays the entire cost of LTD coverage and the cost of coverage may be provided tax-free to you, and is not included in your income. This is called the **"Tax Me Later"** approach, under which future LTD benefits are subject to tax. However, you will have the **premium cost** paid by Inframark included in your income **automatically** unless you opt-out of this income inclusion. Including the LTD premium in your income is called the **"Tax Me Now"** alternative and helps to provide future LTD benefits in a **tax-free** manner.

  See **Exhibit K** for a further explanation of the "Tax Me Now" or "Tax Me Later" alternatives.

- **Business Travel**. Inframark provides a business travel accident policy for you and your family if you experience an accident or illness while traveling for business at **no cost**. This policy provides a benefit up to **1** times your base salary.

  See **Exhibit L**.

- **Legal Services Plan**. You may elect to purchase legal services with **after-tax** payroll contributions. Basic legal services may be obtained via telephone or in person.

  See **Exhibit M**.

What is the Federal tax advantage of participating in the Flex Plan?

By participating in the Flex Plan you may pay for benefits with **pre-tax rather than after-tax** dollars. Thus, you save Federal income taxes on the amount of your contributions. For example, assume you elect to reduce your compensation to pay for unreimbursed healthcare expenses under the Full FSA to approximately **$100** per month, or **$1,200** per year. On these facts you will save approximately **$336** of Federal income taxes by obtaining these benefits on a **pre-tax** basis, assuming you are in the **28%** tax bracket (i.e., **$1,200** x **28%**). In addition, pre-tax employee contributions are not subject to Social Security taxes resulting in **greater savings**. Since you do not pay Social Security taxes on pre-tax employee contributions, however, participation in the Plan may **reduce** your ultimate Social Security benefits. Thus, you may elect to pay for any coverages with **after-tax** dollars prior to the beginning of any Plan Year.

What are the state and local tax implications of Employee Salary Deduction Contributions?

The Plan is granted favorable tax treatment under the Federal law. Not all states recognize the Federal tax treatment provided to such plans. New York, Delaware, Maryland, Virginia and the District of Columbia all recognize the Federal tax treatment available under the Flex Plan. However, New Jersey income taxes **will** be withheld from any **pre-tax** salary reduction contributions to pay for premiums, or to make contributions to the Full FSA, the Limited FSA and the Dependent Care Reimbursement Account. Other states, such as Pennsylvania, will not withhold state taxes from salary reduction contributions made to pay for healthcare coverages, but Pennsylvania taxes **will** be withheld from salary deferral contributions to the Dependent Care Reimbursement Account. You should always consider the state and local tax consequences of your decisions, prior to making any elections.

Is a Same-Sex Spouse treated as a Spouse for purposes of all benefits?

Yes. A spouse is the individual recognized for Federal income tax purposes. In determining if an individual is a same-sex spouse, the **"state of celebration"** rule is used, not the state of residency. Therefore, if you are married in a state or foreign country that recognizes a same-sex spouse relationship, you are married and have a spouse for purposes of the Flex Plan and all related welfare benefits.

How is a Domestic Partner or Civil Union Partner different from a Same-Sex Spouse?

Domestic partners and civil union partners (whether same-sex or opposite-sex) are **not treated** as spouses under Federal law. Therefore, different tax consequences exist. Inframark permits civil union and domestic partners, including same-sex and opposite sex individuals to receive health and other benefits. However, tax rules require you to recognize certain income, subject to income taxes, when such coverage is provided, as further explained below.

Is my contribution for health coverage adjusted during the Plan Year?

If you have a change in status during the Plan Year, your contributions for health coverage may be adjusted. For example, if you change from a full-time to a part-time employee, and your salary is adjusted as a result of this change, you may be required to pay a higher contribution for health coverage. Conversely, if your hours decrease and you change from a full-time employee to a part-time employee, your contributions for health coverage may similarly be adjusted.

Is there any other manner in which my contributions for health coverage may be adjusted?

Yes. If you participate in a wellness program and represent that you have taken certain

actions to receive a credit or avoid a penalty, a mid-year adjustment may occur if your situation changes. For example, if you represent that you do not use tobacco products, but continue to use tobacco products, an adjustment in your contributions may occur for loss of a credit or the imposition of a penalty.

What are the Federal Tax Consequences if I cover a Domestic Partner under the Flex Plan?

Domestic partners are not treated as spouses or other family members under the Federal Internal Revenue Code. Accordingly, to the extent that you elect medical coverage for a domestic partner, and pay for your portion of such costs, your costs will be paid with **after-tax** dollars. Furthermore, the amount of coverage paid for a domestic partner by Inframark must be included in your income. For example, assume the cost for health coverage elected for you and your domestic partner is **$15,000** each year. Further assume, the cost for you and your domestic partner is **$1,500** each, totaling **$3,000** per year. You may elect to pay for the **$1,500** cost for your health coverage on a pre-tax basis, and the **$1,500** cost for domestic partner coverage must be paid with **after-tax** dollars or will be imputed into your income by the end of each tax year. In this example, Inframark pays **$12,000** for the cost of health coverage for you and your domestic partner. The **$6,000** cost for your coverage is a **tax-free** benefit. The **$6,000** cost paid by Inframark for your domestic partner coverage will be included (imputed) into your gross income.

With regard to the Full FSA and the Limited FSA, you may use such accounts to reimburse yourself and your dependents for proper medical expenses. However, the Full FSA and the Limited FSA should **not be used to pay** for healthcare expenses incurred by your domestic partner. If used in this manner, the amounts of reimbursement must similarly be included in your wages.

What are the Federal Tax Consequences if I cover a Civil Union Partner under the Flex Plan?

Civil Union Partners are treated the same as domestic partners for purposes of Federal taxes. Neither a domestic partner nor a civil union partner is treated as spouses.

What are the State Tax Consequences if I cover a Domestic or Civil Union Partner under the Flex Plan?

Many states follow Federal law for purposes of income taxes and imputed income. Thus, there is imputed income for state (and city) income taxes, as in the example above. However, other states do not impute income for the cost of domestic or civil union partners. For example, the cost of coverage for a domestic or civil union partner paid for by Inframark would **not be** considered income for health coverage provided to a partner in New Jersey or in California.

Are there any other limits on the amount I may contribute to the Plan?

Yes. Certain highly paid and key employees may have the contributions to their Accounts reduced under the terms of the Plan. Reductions will only occur when required under Federal law and affected employees will be notified in advance of any reduced contributions.

When must expenses be incurred to be reimbursed?

You are entitled to submit claims for eligible healthcare and Dependent Care Expenses you incurred in 2018 up to **2½** months **"after"** the end of the 2018 Plan Year for reimbursement against amounts withheld from your salary and contributed to your Full FSA or Dependent Care Accounts. Please note that the **2½** month **"**grace period" for incurred expenses in 2018 continues to exist.

For the 2018 Plan Year, up to **$500** of unused funds in your Full FSA will be carried over to the 2019 and future calendar years. If you have a carry over of unused funds in a Health or Limited Purpose FSA, and elect the HDHP in a future Plan Year, funds will carry over to a Limited FSA, and not a Full FSA. This action is required since you **cannot have both** a Full FSA and an HSA at the same time. Moreover, if you have up to **$500** remaining in your Limited FSA, it will carry over to your Limited FSA in the succeeding Plan Year.

For purposes of Dependent Care Benefits, you are entitled to submit claims for eligible healthcare and Dependent Care Expenses you incurred in 2018 up to **2½** months **"after"** the end of the 2018 Plan Year for reimbursement against amounts withheld from your salary and contributed to your Full FSA or Dependent Care Accounts.

How do I obtain reimbursement from my Full FSA, Limited FSA and Dependent Care Reimbursement Accounts?

The FSA Administrator, which is PayFlex Systems USA ("PayFlex"), is responsible for reimbursing all participants for expenses properly charged to their Full FSA, Limited FSA and Dependent Care Reimbursement Accounts under the Plan. After you have incurred eligible expenses, you may submit a Reimbursement Request Form with supporting documents (billing statements, payment receipts, etc.) to the Administrator without any minimum requirements. Reimbursement Request Forms are available from your Human Resource Representative.

Reimbursements for eligible healthcare and Dependent Care Expenses may be requested for expenses incurred during the Plan Year and for such expenses incurred up to **2½** months after the end of each Plan Year (i.e., the "grace period"). However, reimbursement must be requested within a **"run-out period"** that ends **4** months after the end of the Plan Year (i.e., each April 30). It is important to distinguish between:

- The **2½** month grace period under which Dependent Care Expenses may be incurred in 2019 and reimbursed with amounts in your Dependent Care Account as of

December 31, 2018.

- The **"run-out period"** that ends **4** months after the end of the Plan Year, and allows you to submit expenses incurred during 2018 against your account as of December 31, 2018.

- The **$500** rollover rule that applies to the Full and Limited Purpose FSAs if you elect to participate in the HDHP. These rules are further addressed below.

The Administrator will send you a check for the total eligible expenses to be reimbursed. The Plan permits reimbursement during the Plan Year up to the full amount to be contributed to your Full FSA during the Plan Year. Reimbursements from your Dependent Care Reimbursement Account may never exceed the amount contributed and available in your Account when the reimbursement is requested.

To illustrate these rules, let's assume you elect to contribute to a Full FSA. After you enrolled in the Plan, you purchase contact lenses and they are not covered by any healthcare plan. Your Full FSA may be used to pay the cost of these lenses, since contact lenses are an expense eligible for reimbursement under your Full FSA.

You need only incur Dependent Care Expenses during the Plan Year (or within **2½** months thereafter); complete a Request for Reimbursement Form with supporting documentation and submit it, along with proof of your incurred expenses, to the FSA Administrator. Your request will be processed and a reimbursement draft will be made payable to you and forwarded to your home.

How are my contributions to the Flex Plan made if I am on paid or unpaid family leave?

In general, when you are out on a paid family leave, such as when you are using vacation or sick time to continue your salary, all contributions will continue to be withheld from your salary. If you are on an unpaid family or other leave, you will be given the following alternatives:

- You may **"prepay"** your employee contributions to pay the cost of premiums, and make contributions to the Full FSA, the Limited FSA and the Dependent Care Reimbursement Account. These contributions may be made on a pre-tax basis for the anticipated period of your leave.

- You may **continue** to make your premium and other Salary Deferral Contributions to all appropriate accounts during the period of your leave, with **after-tax** dollars. These contributions are made on an after-tax basis if there will be no salary from which they can be withheld on a pre-tax basis.

- Lastly, you can **"catch-up"** with any required contributions upon your return from leave. Leave amounts will be paid with **pre-tax** dollars, if they are withheld from your salary upon your return. However, in the event that you do not return to work, you will be required to pay Inframark the amount of all previously required contributions, with after-tax dollars.

The above rules will be explained to you at the time that you take your leave of absence, in order to permit you to elect which alternative you prefer.

Can I ever forfeit salary reduction contributions paid to my Full FSA, my Limited FSA or Dependent Care Accounts?

Yes. If you do not incur healthcare expenses in an amount equal to your contributions to your Full and Limited FSAs, or do not incur dependent care expenses equal to your contributions to your Dependent Care Account during a Plan Year (or within **2½** months thereafter for Dependent Care Expenses), such excess contributions **will be forfeited**. This forfeiture **must occur** in order for the Plan to receive the favorable tax treatment permitted under Federal law (i.e., for your contributions to pay benefits to be made with pre-tax dollars). This is known as the **"use it or lose it"** rule. All forfeitures will be applied to pay the expenses associated with the administration of the Flex Plan.

Remember, as a result of the **2½** month rule, you did not lose any portion of your Dependent Care Reimbursement Accounts if you incurred eligible expenses within **2½** months **after the end** of the applicable Plan Year.

As noted above, an **exception** was established by the IRS to the **"use it or lose it"** rule. Up to **$500** of unused contributions may be rolled over from the 2018 to the 2019 calendar year to pay for health expenses incurred in 2019 and future years.

This **$500** carry over does **not affect** the **$2,700** that you may generally elect to defer to the Full or Limited FSAs. Thus, your Health FSA may have a maximum of up to **$3,150 ($2,700 + $500)** available for health expenses in 2019.

The **$2,700** Health FSA limit was **increased** by Inframark for 2019. Future Health FSA limits will be implemented by Inframark, if sufficient time exists to communicate such change.

Additional Plan Provisions

How are elections made and when may they be changed?

You must decide whether you wish to waive healthcare, dental or vision benefits when you are eligible to you participate in the Flex Plan. You must also decide the amount you wish to reduce your compensation before you begin participating in the Plan and must execute a Benefits Enrollment Form to authorize Inframark to reduce your compensation for the cost of the

coverage you elect. Once you have made an election for a Plan Year you **cannot change** your elections unless a **significant family event** or another **qualifying event** occurs. Different rules apply to change elections regarding healthcare coverages, and Full or Limited FSAs.

The circumstances which generally permit you to change your **healthcare, dental or vision elections**, and contributions to the Full or Limited FSAs during the Plan Year include the following:

- A **change in "status"** involving: (i) the birth, adoption or placement for adoption, or death of a child; (ii) a change in marital status (including marriage, death, divorce, legal separation or an annulment); (iii) the death of a family member; (iv) the termination or commencement of employment by an employee, spouse or dependent; (v) a reduction or increase in hours for an employee, spouse or dependent, including switching from part-time to full-time status, a strike or lock out, the start or return from an unpaid leave of absence, or a loss or reduction in benefit coverage; (vi) an event causing a dependent to satisfy or cease satisfying any coverage requirements due to age, student status or any similar circumstance provided in a health plan and (vii) a change in place of residence or work for you, a spouse, or dependent (without any changes under the Full or Limited FSAs).

- A **significant increase** in the employee cost for healthcare, dental, vision or dependent care non-relative coverage as a result of actions taken by an independent third party (except for the Full or Limited FSAs).

- A **significant decrease** in the cost of coverage allows for a decrease in your contributions and the ability to enroll in the program with the decreased cost.

- A **significant curtailment** with a loss of any coverage such as a substantial decrease in provisions under a program, or a reduction in benefits.

- A **significant curtailment** without a loss of coverage, allows for an election of similar coverage (but does not apply to Full or Limited FSAs).

- The **addition** or **elimination** of a benefit option.

- A **significant improvement** in a benefit option.

- A **change in coverage** of a spouse or dependent under another employer's plan.

- The **taking of a leave** under the Family and Medical Leave Act.

- A **judgment, decree** or **order** resulting from a divorce, legal separation, annulment or change in legal custody requiring coverage for a child.

- A **"special enrollment"** event as required to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), such as marriage, birth and adoption (except no changes are allowed for Dependent Care Reimbursement accounts).

- A **separation from service**.

- Any **entitlement** to Medicare or Medicaid.

In addition to requiring the occurrence of an event described above, in order to allow you to change some elections, your election must be **"consistent" with the reason for a change**. For example, if your spouse becomes eligible for coverage under a plan maintained by his or her employer, any existing coverage for your spouse under the Flex Plan may be dropped if your spouse accepts such new coverage. However, if new coverage is made available, and your spouse does not make any changes in healthcare coverage, you will not be entitled to drop your spouse from coverage during any Plan Year, since such action is not consistent with a change in status.

The rules restricting your ability to change your elections **are required by law**. If you ever wish to change your elections, you should contact the Plan Administrator.

If I am called up from military service, will I have access to my Full or Limited FSAs?

Yes. If you elect to make pre-tax contributions to the Full or Limited FSA, and you are called to or ordered to report to active duty as a reservist for a period of at least **180** days or for an indefinite period, you may be eligible to receive reimbursement of the balance of your unused Full or Limited FSA Account on an **after-tax** basis. This distribution is known as a Qualified Reservists Distribution ("QRD"). A QRD is permitted under the Inframark Flex Plan.

Do I need to make a new election each Plan Year?

Maybe. Salary deferral elections to pay for any healthcare, dental or vision coverages with **pre-tax** contributions will continue from Plan Year to Plan Year if not changed. However, you must make **new elections** each Plan Year to continue to participate in the Full or Limited FSAs, Dependent Care Reimbursement Accounts or the Vacation Cash-Out or purchase benefits.

May I change my elections if I wish to obtain health coverage under an Exchange or Marketplace Health Plan under ACA?

You may generally not change your election during each Plan Year to elect Exchange or Marketplace health coverage, since the Plan Year for the Flex Plan and Exchange Health Plans coincide with the calendar year. However, you may elect Exchange or Marketplace health

coverage if you have a reduction in hours and would otherwise lose health coverage, if it weren't for ACA. Under this circumstance, you may elect an Exchange or Marketplace, or another health plan, as long as you **represent that you intend** to enroll in another health plan, and **actually enroll** in a new health plan no later than the first day of the second month following the month that includes the date the original coverage is revoked. However, please remember if you do not maintain health coverage you may be subject to penalties under ACA.

Who administers the Plan?

The Plan Administrator is Inframark. However, Inframark has delegated the daily responsibility for administering the Flex Plan to Vantagen.

Will I receive any statement from my employer reflecting my contributions to and reimbursements from the Plan each year?

Yes. For tax purposes Inframark must provide you with a written statement explaining the amount paid or expenses incurred in providing dependent care assistance during each calendar year. This information must be furnished to you on or before each **January 31** in order for the Federal income tax exclusion for dependent care expenses to exist and is included in your Form W-2. You are therefore encouraged to submit outstanding reimbursements for dependent care expenses promptly after the end of each calendar year.

How are benefits funded?

The Full and Limited FSAs and Dependent Care Reimbursement Accounts are Funds through salary reduction contributions made by employees electing to participate in the Plan. It is not the intent of Inframark to make any other contributions to the Plan, although Inframark will continue to pay its portion of healthcare and dental premiums outside the Flex Plan.

When does participation under the Flex Plan end?

Participation under the Flex Plan ceases when you no longer satisfy the eligibility requirements to participate in the Flex Plan or any underlying insurance program, the date you elect to cease participating in the Plan during an Open Enrollment Period or due to a change in family status or other qualifying event, or when the Plan is terminated.

What happens if my employment terminates?

If your employment with Inframark terminates, your benefits under the Flex Plan generally end on **midnight of your termination date. [To confirm.]** The full amount of all regular premium contributions will be withheld through your date of termination without any proration.

If your employment with Inframark is terminated prior to the end of the Plan Year, you are permitted to submit requests for reimbursement to the Full or Limited FSA and Dependent Care Reimbursement accounts for expenses incurred **prior to** your termination, for **3** months following your termination date. In no event, however, may dependent care expenses be submitted for reimbursement after any **January 20th** following the end of any calendar year. Any unused contributions in excess of your reimbursable expenses will be **forfeited**.

Am I entitled to continue any benefits under the Plan if my employment should terminate?

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") you may be entitled to continue certain healthcare benefits under all healthcare, dental and vision programs after a termination of employment or other qualifying event. If you are entitled to continuation health coverage, Inframark will provide you with additional information upon the occurrence of a qualifying event. Any extension of healthcare coverage will generally be on an **after-tax** basis.

The Dependent Care Reimbursement coverage is not extended beyond a separation from service with Inframark, except for claims incurred prior to your separation from service.

May I Elect COBRA Coverage for the Full and Limited FSAs?

Yes. The Full and Limited FSAs are health plans for purposes of COBRA elections. However, you may only elect COBRA coverage through the end of the Plan Year in which a separation from service has occurred for the FSAs.

May the Plan be Amended or Terminated?

Inframark has adopted the Flex Plan with the expectation that it will be continued for the benefit of employees. However, Inframark reserves the right to amend, modify or terminate the Flex Plan, and any underlying health or welfare plan, at any time. If the Flex Plan is terminated, you may continue to obtain reimbursement for eligible expenses incurred prior to a termination, from the amounts credited to your Accounts.

Who will interpret the Plan?

The Plan Administrator will have the complete discretion to interpret all provisions of the Plan.

Who pays the expenses to administer the Plan?

Inframark generally intends to pay all expenses required to administer the Plan, as reduced by any forfeitures.

Upon what information may I rely upon in making my decisions under the Plan?

A representative of the Human Resource Department, or any representative of Inframark appointed by the Administrator, will discuss any questions you may have concerning the Plan and how it applies to you. In no event should you rely on any statements made by anyone other than a designated representative of Inframark concerning your rights or obligations under the Plan.

May my benefits under this Plan be assigned to anyone?

No. The Plan does not allow you to transfer or assign any part of your benefits under the Plan. This requirement is to protect your benefits from the reach of creditors until you are entitled to them under the terms of the Plan.

How are claims for benefits processed?

All claims under any healthcare, dental or vision programs will be governed by the terms of the insurance contract or other plan document establishing such benefits. Neither this Summary Plan Description nor the actual Flex Plan change any rights, benefits or procedures under any insured or self-insured plans, and the claims procedures of such plans will be controlling. You should review the separate Summary Plan Description prepared for the healthcare and dental plans to review the claims procedures in existence.

The Administrator or any individuals, committee or third-party administrator, (the "Claims Coordinator"), which is appointed, will make the initial determination of your right to reimbursement from any Full or Limited FSAs or Dependent Care Spending Accounts.

The Claim Coordinator will make all determinations as to your right to a benefit under the Plan. If the Claim Coordinator denies in whole or in part any claim for a benefit the Claim Coordinator will furnish you with notice of the decision not later than **30** days after receipt of the claim by the Claim Coordinator, unless special circumstances require an extension of time for processing the claim. If such an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial **30** day period. In no event will such extension exceed the period of **15** days from the end of such initial period. The extension notice will 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, you may assume the claim has been denied.

Although Dependent Care Accounts are not subject to ERISA, the general Claims Procedures will apply to Dependent Care Reimbursement Accounts except for the Post-Service and other health related procedures.

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

- Notification of benefit determination will be provided to you within **30** days of making a claim.
- Extensions due to matters beyond the control of the Plan may be up to **15** days.
- Extensions due to insufficient information may be up to **15** days.
- Responses following notice of insufficient information will be provided to you within **45** days.
- Review of adverse benefit determinations will be made within **60** days of a request for reconsideration.

The Claims Coordinator will provide you with written or electronic notification of any adverse benefit determination. The notice will be issued in accordance with the above timetable and will state, in a manner calculated to be understood by you:

- The specific reason or reasons for the adverse determination.
- Reference to the specific Plan provisions on which the determination was based.
- A description of any additional material or information necessary for you to perfect the Claim and an explanation of why such material or information is necessary.
- 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 will include a statement of your right to bring a civil action under Section 502 of ERISA following an adverse benefit determination on review.
- A statement that you are 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. **You 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**.

- If an adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to you upon request.

- If the adverse benefit determination is based on the healthcare 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 your healthcare circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

When you receive an adverse benefit determination, you 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 will be established by Inframark as the "Named Appeals Fiduciary", as required under ERISA for reviewing claims. You may submit written comments, documents, records, and other information relating to the Claim. If you so request, you will 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 will 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.

Your Rights Under ERISA

What rights do I receive under ERISA?

As a participant in the Inframark Flexible Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) for certain benefits. ERISA provides that all participants of an ERISA plan will be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements,

and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

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

HIPAA Creditable Coverage

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

HIPAA Privacy

A federal law, HIPAA, requires that health plans protect the confidentiality of your protected health information. A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment and is available from the benefits manager. The Flex Plan is part of the Health Plan for purposes of HIPAA.

The Health Plan, and as the "Plan Sponsor", will not use or further disclose information that is protected by HIPAA, known as protected health information ("PHI"), except as necessary for payment, treatment, health plan operations and plan administration, or as permitted or required by law. As required by law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Health Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department

of Health and Human Services if you believe your rights under HIPAA have been violated.

The Health Plans maintain a Notice of Privacy Practices, which provides a complete description of your rights under the HIPAA's privacy rules. For a copy of the Notice of Privacy Practices, please contact your local Human Resources Representative. If you have questions about the privacy of your health information please contact the Director of Human Resources. If you wish to file a complaint under HIPAA, please contact Chris Brutsche, Manager, Benefits and Compensation, Inframark, LLC, 220 Gibraltar Road, Suite 200, Horsham, Pennsylvania 19044, (215)283-6110.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called Afiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within **30** days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to **$147**a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a healthcare child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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NOTHING CONTAINED IN THE PLAN OR THIS SUMMARY PLAN DESCRIPTION WILL BE CONSTRUED AS A CONTRACT OF EMPLOYMENT BETWEEN INFRAMARK AND

ANY PERSON, NOR WILL THE PLAN OR SUMMARY PLAN DESCRIPTION BE DEEMED TO GIVE ANY PERSON THE RIGHT TO BE RETAINED IN THE EMPLOY OF INFRAMARK OR LIMIT THE RIGHT OF INFRAMARK TO EMPLOY OR DISCHARGE ANY PERSON OR TO DISCIPLINE ANY EMPLOYEE. FURTHERMORE, THE PLAN ADMINISTRATOR WILL HAVE COMPLETE DISCRETION IN INTERPRETING ALL PROVISIONS OF THE PLAN.

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INFRAMARK, LLC
FLEXIBLE BENEFITS PLAN

General Information Sheet

Name of Plan. The official name of the Plan is the Inframark Flexible Benefits and Welfare Benefit Plans.

Plan Sponsor. The Plan Sponsor is Inframark, LLC, a Pennsylvania Corporation ("Inframark"). The Plan Sponsor's address is 220 Gibraltar Road, Suite 200, Horsham , Pennsylvania 19044.

Identification Numbers. The Federal Employer Identification Number ("EIN") assigned by the Internal Revenue Service to Inframark is62-1168252.

Plan Number. The Plan number assigned by Inframark to the Plan is 501.

Plan Year. The Plan Year, for purposes of maintaining the Flex Plan's records, begins on each January 1 and ends each December 31, except as otherwise indicated.

Plan Administration. Inframark is the Plan Administrator and is responsible for the overall operation and administration of the Plan, unless the administration is delegated to any individual or legal entity.

Agent For Service of Legal Process and Named Fiduciary. Inframark is the agent for legal service and named fiduciary of the Plan. Its address and telephone number are Plan Administrator, Inframark, LLC, 220 Gibraltar Road, Suite 200, Horsham, Pennsylvania 19044, (215) 646-9201.

Type of Plan. The Plan is a welfare and fringe benefit plan.