INFRAMARK, LLC

Welfare Benefit Plan – Wrap Plan Document

January 1, 2023

INFRAMARK, LLC
WELFARE BENEFIT PLAN – WRAP PLAN DOCUMENT

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WHEREAS, Inframark, LLC ("Inframark" or the "Employer") maintains various Health and other Welfare Benefit Plans; and

WHEREAS, all Welfare Plans are documented in various Plan documents, Booklets, Summary Plan Descriptions ("SPDs"), insurance policies and Third Party Administrator ("TPA") Service Agreements; and

WHEREAS, Inframark established an integrated Wrap Plan to incorporate all Welfare Benefit Plans under a single Plan, and to ensure that a Plan document is maintained for each Welfare Benefit Plan, as required under the Employer Retirement Income Security Act of 1974, as amended ("ERISA"); and

WHEREAS, the Wrap Plan was last amended and restated as of January 1, 2018; and

WHEREAS, Inframark wishes to amend and restate the Wrap Plan effective as of January 1, 2023.

NOW, THEREFORE, this Welfare Benefit Plan - Wrap Plan document shall serve as the Plan document for all Welfare Benefit Plans identified in the attached **Appendix A**, effective as January 1, 2023.

ARTICLE I

INTRODUCTION

1.1 **Name**. The Inframark, LLC Welfare Benefit – Wrap Plan Document (the "Plan").

1.2 **Construction**. This Plan is intended to be an employee welfare benefit plan under Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and is to be interpreted and administered accordingly. Whenever Plan language is drafted with respect to requirements under the Internal Revenue Code, as amended (the "Code") or ERISA or regulations or rulings thereunder, such language shall be interpreted as intended only to implement such statutes, regulations or rulings unless additional rights or benefits are given explicitly and clearly by the language of the Plan.

1.3 **Governing Documents**. This written plan document, together with the Summary Plan Description, any separate document setting forth the terms of any Benefit that is a component of this Plan, and Funding Instruments, are the governing plan documents under ERISA Section 402(a)(1) with respect to the Plan. If there is a Funding Instrument for a Benefit and an ambiguity between the Funding Instrument and another document, then such Funding Instrument shall constitute the governing document with respect to such Benefit. In the event of any discrepancy between this Plan document and the SPD or other written communications, this Plan document shall prevail, unless otherwise specifically provided. In the event of any discrepancy between this Plan document and any of the Funding Instruments, the terms of the Funding Instrument shall govern. For purposes of this Section, a "Funding Instrument" means a trust agreement, an insurance policy, contract or certificate of coverage, or another agreement, as in effect at the time with respect to which the term is used, that provides for Benefits, the administration of Benefits or for the holding of any assets of the Plan with respect to the provision of Benefits, excluding only stop-loss or other similar funding vehicles.

ARTICLE II

DEFINITIONS

As used in the Plan, the terms defined below, when capitalized, shall have the meanings assigned to them in this Article unless a different meaning is plainly required by the context.

2.1 **Benefits**. A Benefit or Benefits means one or more of the benefits as determined under Section 4.2 and listed in **Appendix A**.

2.2 **Board**. The Executive Committee of Inframark, LLC, which serves under authority granted to it by the Board.

2.3 **Civil Union Partner**. A Civil Union Partner is any same-sex or opposite-sex Civil Union Partner, as recognized under state law. The definition for a Domestic Partner shall encompass civil unions.

2.4 **Code**. The Internal Revenue Code, as amended.

2.5 **Committee**. The Administrative Committee to which the Company has delegated Plan authority as described in Article V.

2.6 **Company**. Inframark, LLC and any subsidiary or affiliated organization, and any successor which, with the approval of the Company, and subject to such conditions as the Company may impose, adopts the Plan. Affiliates that participate in the Plan as "Participating Employers" include Inframark, LLC, EIN 62-1168252, previously known as Severn Trent Environmental Services ("STES"); Inframark (PA), LLC, EIN 23-2660702, previously known as Severn Trent Services, LLC ("STS, LLC") and Inframark (DE), LLC, EIN 23-2632347, previously known as Severn Trent (Del).

2.7 **Dependent**. A 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.

2.8 **Domestic Partner**. A 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 **12** months;

(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

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

2.9 **Effective Date**. The effective date of this Plan is January 1, 2023.

2.10 **Eligible Employees**. This is defined in Article III.

2.11 **Employee**. For purposes of this Plan, the term Employee means a person currently performing services under the Company's control, as defined under each Welfare Benefit Plan incorporated into this Wrap Plan Document. An individual shall be treated as an Employee only if he or she is a common law employee of the Company. The term Employee does not include a person (a) whom the Committee determines has been engaged by the Company as an independent contractor or temporary employee, (b) leased employees, (c) an

employee included in a unit of employees covered by a collective bargaining agreement with the Company that does not specifically provide for coverage of the employee under this Plan, (d) an employee under the age of eighteen, and (e) an employee who is not a citizen or permanent resident of the United States of America and whose primary place of employment is outside of the United States of America. Once an individual terminates his or her employment with the Company, he or she shall cease to be an Employee. A person the Committee determines is not an Employee shall not be eligible to participate in the Plan regardless of whether such determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters.

2.12 **ERISA**. The Employee Retirement Income Security Act of 1974, as amended.

2.13 **Participant**. Any Eligible Employee or Retiree eligible for benefits under Article IV and their respective Spouses and Dependents eligible for benefits under Article IV.

2.14 **Plan**. The Inframark, LLC Welfare Benefit Plan.

2.15 **Plan Year**. The **12**-month period beginning January 1 and ending December 31.

2.16 **Retiree**. A Participant who (a) terminates employment with the Company, (b) was a Participant immediately prior to termination of employment, (c) meets the conditions of Section 3.3 and (d) is eligible for Benefits under Article IV.

2.17 **Spouse**. A Spouse means the person to whom a Participant is legally married at the time of such determination. The Plan recognizes 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 former Participant to whom such deceased former Participant was legally married (as determined by the Administrative Committee) on the date of the Participant's death.

ARTICLE III

ELIGIBLE EMPLOYEES

3.1 **In General**. Those Employees who may become eligible to receive benefits under the Plan are described in this Article.

3.2 **Eligible Employees**. Each Employee working for the Company, or an Affiliate, who is regularly scheduled to work **30** hours per week or more, shall be eligible for participation in most Welfare Benefit Plans on the first day of the month after completion of **30** days of service, in accordance with all Plan documents incorporated into this Plan.

The eligibility requirements may be different for each Affiliate, as documented in each Affiliate's employment policies and procedures or as otherwise governed under the terms of any underlying Plan.

3.3 **Eligible Retiree**. A Participant who, at termination of employment, meets the provisions of any Retiree Plan incorporated into this Plan, shall be eligible for benefits in accordance with the provisions of this Plan and the appropriate Retiree Plan document. Unless addressed in the future, no Retiree Plans exist under the Wrap Plan.

3.4 **Rehires**. Employees who are rehired within a period of **12** months after a separation from service shall be granted past service credits and shall be immediately eligible to re-enter all Welfare Benefit Plans, unless provided otherwise under the terms of any specific insurance or Plan documents.

3.5 **Acquisitions**. In connection with acquisitions, Inframark may elect to waive the basic eligibility rules and to grant past service credits to employees of any acquired entity, to the extent not inconsistent with any insurance policies or Plan provisions, or with the prior approval of any insurance carriers, stop-loss carriers and/or entities providing coverage.

ARTICLE IV

PARTICIPATION, BENEFITS AND CONTRIBUTIONS

4.1 **Participation**. Eligible Employees and Retirees who satisfy the eligibility requirements of Article III and complete any enrollment and election requirements prescribed by the Committee or its delegate(s) shall participate in the Plan Benefits, and their eligible Spouses, Dependents and Civil Union or Domestic Partners shall be eligible to become participants. Participation and coverage shall be determined in accordance with the Benefit programs adopted by the Company or Committee from time to time, and incorporated into this Plan.

4.2 **Benefits**. Participants are entitled to the amount and type of benefits as determined according to the benefit programs adopted by the Company or Committee from time to time, subject to Section 4.4 (the "Benefits"). Benefits provided under the Plan are listed in **Appendix A** and include choices made under the separate Inframark Flexible Benefits Plan, which is not a component of this Plan. All Participants need not be provided the same Benefits, or additional conditions, such as different age and years of service, may be required for a particular class of Participant to receive a particular Benefit or level of benefit.

4.3 **Contributions**. Benefits shall be funded by a combination of contributions made by the Company, Participants, and Beneficiaries, as determined according to the benefit programs adopted by the Company or Committee from time to time, subject to Section 4.4. The Company and/or the Committee reserves the right to amend and revise at any time the applicable contribution rates to be made by the Company and the Participants for Benefits under the Plan. Contributions from the Company and/or Eligible Employees may be held under or paid to one or more of the following vehicles: insurance policies or arrangements, arrangements with health maintenance organizations or trust funds established by the Company. In addition, benefits may be paid directly from the general assets of the Company. The Company shall have no liability for benefits provided through insurance or pursuant to an agreement with a health maintenance organization.

4.4 **Discretion**. The Committee is expressly empowered to determine all of the following within its discretion and in accordance with applicable law: (a) whether and to what extent Eligible Employees, Retirees and their Spouses and Dependents are eligible to become Participants under this Plan; (b) the effective date for eligibility to receive benefits under this Plan; and (c) the amount and types of benefits Participants shall receive under this Plan.

4.5 **Declining Retiree Coverage**. If a Retiree participates in the Benefits pursuant to Section 4.2, but declines any Benefit at or after termination of employment (including electing COBRA coverage in lieu of Benefits as a Retiree as provided in Section 4.2), then that Retiree and any Spouse and/or Dependent of such Retiree shall not be entitled to re-commence that Benefit under the Plan at a later date., subject to the terms of the applicable Retiree Plan document.

4.6 **Termination of Coverage**. Benefits shall terminate according to the Benefit programs adopted from time to time, or upon a Plan amendment terminating one or more Benefits or termination of the entire Plan under Article VI.

4.7 **Coverage under the Family and Medical Leave Act**. The Plan shall provide coverage for an Eligible Employee to the extent necessary to comply with FMLA, and the Plan shall be interpreted and administered as necessary to comply with FMLA and the rulings and regulations issued thereunder.

4.8 **Coverage under Qualified Medical Child Support Orders**. The Plan shall provide coverage to a child, including an adoptive child, to the extent required by a qualified medical child support order defined under Section 609 of ERISA, and the Plan shall be interpreted and administered as necessary to comply with Section 609 of ERISA and the rulings and regulations issued thereunder.

4.9 **Coverage under the Uniformed Services Employment and Reemployment Rights Act**. To the extent required by the Uniformed Services Employment and Reemployment Rights Act and the rulings and regulations thereunder, an Eligible Employee who enters military service shall have the right to continue coverage under the Plan for the period prescribed by applicable law.

4.10 **Health Insurance Portability and Accountability Act of 1996**. To the extent required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the rulings and regulations thereunder, an Eligible Employee shall become eligible to participate in the Plan no later than such time as required under HIPAA, and the Plan shall be subject to the special enrollment, pre-existing condition limitations and nondiscrimination in health status provisions of HIPAA. The Plan shall also comply with the privacy and security regulations of HIPAA in accordance with the provisions set forth in Article VIII.

4.11 **Mental Health Parity**. To the extent required by the Mental Health Parity Act of 1996 and the rulings and regulations thereunder, the Plan shall provide mental health benefits to the same extent as other medical benefits with respect to the applicable of aggregate lifetime and annual dollar limits under the plan. In addition, the Plan shall also comply with the Mental Health Parity and Addiction Equity Act of 2008, including to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

4.12 **Women's Health and Cancer Rights Act**. To the extent required under the law of the Women's Health and Cancer Rights Act of 1998 and the rulings and regulations thereunder, the Plan shall provide certain benefits related to benefits received in connection with a mastectomy. In the case of an Eligible Employee who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the coverage shall be provided in a manner determined in consultation with the attending physician and the patient for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, subject to annual deductibles and cost provisions such as other medical and surgical benefits covered under the Plan.

4.13 **Newborns' and Mothers' Health Protection Act**. To the extent required by the Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA"), the Plan shall provide that

coverage for childbirth may not be limited to a hospital stay of less than **48** hours for normal delivery, or less than **96** hours for cesarean section, or require the provider to obtain approval for shorter hospital stays. The requirement shall not apply if the attending provider, in consultation with the mother, decides to discharge the mother or newborn earlier than the time prescribed by the NMHPA.

4.14 **Compliance with Applicable Laws**. The Plan shall comply with the applicable laws affecting group health plans, including provisions of the Patient Protection and Affordable Care Act of 2010, as amended and the rulings and regulations thereunder, as well as the Genetic Information Nondiscrimination Act of 2008 and the Children's Health Insurance Program Reauthorization Act of 2009.

4.15 **Continuation of Coverage**. "Qualified beneficiaries" (within the meaning of Section 4980B(g)(1) of the Code of Section 607(3) of ERISA) may, upon the occurrence of a "qualifying event" (within the meaning of Section 603 of ERISA or Section 4980B(f)(3) of the Code), elect to purchase COBRA continuation coverage under any Benefit Program which is a "group health plan" (within the meaning of Section 607(1) of ERISA or Section 4980B(g)(2) of the Code) to the extent such continuation coverage is required by the Code or ERISA. Participants and any beneficiaries under any Benefit Program shall also have the continuation coverage rights and such other rights as may be mandated by the Family and Medical Leave Act of 1993, The Uniformed Services Employment and Reemployment Rights Act of 1994, and other applicable federal law, or as may be mandated by applicable state law which is not preempted by ERISA. When the provisions for COBRA continuation coverage or other continuation coverage are set forth in an applicable Benefit Program, such applicable documents for the Benefit Program shall govern except to the extent such language fails to comply with requirements or applicable law or fails to determine the right or liability of the party in which case the provisions of this Section 4.15 shall govern.

(a) **COBRA**. Employees, Spouses and Dependents shall have the right to purchase continuation coverage under this Plan provided such individuals were covered under the Plan on the date immediately preceding the date of a qualifying event or become covered under any Health Plans that are incorporated into this Plan, on the day that may have preceded such qualifying event. Notwithstanding the foregoing, if a Retiree (and Spouse and Dependent(s)), in connection with the Retiree's termination of employment, is/are offered and elects to receive Benefits as a Retiree (and eligible Spouse/Dependent(s)) under this Plan, then coverage under this Plan shall be in lieu of or run concurrently with any period of coverage such individuals would otherwise have been eligible for under Section 4980B(f) of the Code and part 6 of Subtitle B of Title I of ERISA ("COBRA").

(1) A qualifying event means any of the following, the occurrence of which would result in loss of coverage under the Plan were it not for the right to purchase COBRA continuation coverage:

(A) For Employees, termination of employment for any reason other than gross misconduct, or loss of eligibility due to reduction in hours worked by the Employee;

(B) For Spouses and Dependents, death of the Employee, divorce of the Employee and spouse, legal separation of the Employee and spouse, reduction in hours worked by the Employee or termination of employment by the Employee for any reason other than gross misconduct, entitlement of the Employee to benefits under Title XVIII of the Social Security Act (relating to Medicare), or ceasing to qualify as a Dependent child under the Plan.

(2) COBRA eligible Employees, Spouses and Dependents shall remain eligible so long as the Company or Plan Administrator is notified of the election of COBRA continuation coverage on a form provided for that purposes within **60** days of the later of the date such qualified beneficiary's coverage under the Plan would otherwise terminate by reason of a reduction in hours worked by the Employee or termination of employment of the Employee for any reason other than gross misconduct or the date notice of eligibility is sent to the individual by the Plan Administrator as required under COBRA, and, the qualified beneficiary pays the initial required premium no later than the date **45** days after the date on which COBRA continuation coverage was elected. Until expiration of the election period, a qualified beneficiary may change or revoke any election. Failure to elect COBRA continuation coverage within the prescribed election period shall result in a waiver of the right to COBRA continuation coverage.

(3) COBRA continuation coverage shall terminate on the date on which the earliest of the following occurs:

(A) The last day of the month preceding the date the qualified beneficiary fails to pay a subsequent required premium within **30** days of the date it is due;

(B) The date the qualified beneficiary first becomes, after the date of making a COBRA election, entitled to Medicare;

(C) The date the qualified beneficiary first becomes, after the date of making a COBRA election, covered under another group health plans, as defined in Section 5000(b)(1) of the Code, not containing a limitation or exclusion as to any pre-existing condition of such individual (other than such an exclusion or limitation which does not apply to, or is satisfied by, such beneficiary by reason of HIPAA);

(D) **36** months from the date on which the following occurs: death of the Employee, divorce of the Employee and Spouse, legal separation of the Employee and Spouse, entitlement of the Employee to benefits under Title XVIII of the Social Security Act (relating to Medicare), or ceasing to qualify as a Dependent child under the Plan.

(E) **18** months from the date on which the Employee is terminated from employment for any reason other than gross misconduct, or loss of eligibility due to reduction in hours worked by the Employee. If a second qualifying event occurs subsequent to the Employee's termination from employment for any reason other than gross misconduct, or loss of eligibility due to reduction in hours worked, an additional period of coverage shall be allowed for Dependents in accordance with applicable law.

(F) The date the Company terminates all group health plans.

(G) In the case of a qualified beneficiary who is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the qualifying event or at any time during the first **60** days of continuation coverage, the **18**-month period set forth in Subsection 3(e) above shall be extended to **29**-months; provided that such individual notifies the Plan Administrator of such determination within **60** days after the date of such determination but in no event later than the end of such **18**-month period; and provided further that if the qualified beneficiary does not remain disabled during the extended period, coverage shall cease with the month that begins more than **30** days after the date of the final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (and such qualified beneficiary shall be responsible for notifying the Plan Administrator of any final determination under such Title(s) that he or she is no longer disabled within **30** days of the date of such determination).

(H) In the case of a qualifying event that is a reduction in hours worked by the Employee or termination of employment of the Employee for any reason other than gross misconduct that occurs less than **18** months after the date the Employee becomes entitled to Medicare, **36** months from the date the Employee becomes entitled to Medicare.

ARTICLE V

ADMINISTRATION

5.1 **In General**. The Company is the Plan Administrator and is a named fiduciary that has the discretionary authority to control and manage the operation and administration of the Plan; provided, however, that the Company may delegate its duties and authority as Plan Administrator to one or more of its employees or officers, or such other persons as the Plan Administrator deems appropriate including the Inframark Employee Benefits Committee (the "Committee"). Members of the Committee and all other Plan fiduciaries may serve in more than one fiduciary capacity with respect to the Plan. The Committee shall serve pursuant to the provisions of this Plan. Notwithstanding any provisions to the contrary, any insurance company or health maintenance organization issuing and insurance or HMO contract or an administrative services organization issuing an administrative services agreement shall have sole discretion with respect to the matters for which it is made responsible under such insurance, HMO contract or administrative services agreement, and to the extent required by ERISA, shall acknowledge in writing that it is a fiduciary with respect to those responsibilities.

5.2 **Powers of the Committee**. The Committee shall have all powers necessary or incident to its office as Plan Administrator. Such powers include, but are not limited to, full discretionary authority to:

(a) Interpret the Plan and decide all matters arising under the Plan;

(b) Prescribe rules for the operation of the Plan;

(c) Determine eligibility and enroll employees in the Plan;

(d) Comply with the requirements of reporting and disclosure under ERISA and any other applicable law and to prepare and distribute other communications to employees as part of the plan operations;

(e) Prescribe forms to facilitate the operation of the Plan;

(f) Secure government approvals for the Plan;

(g) Construe and interpret the terms of the Plan, including the power to remedy possible ambiguities, inconsistencies or omissions;

(h) Determine the amount of benefits and eligibility for benefits;

(i) Implement computer and telecommunications systems to assist administration of the Plan and maintain records of the Plan;

(j) Litigate, settle claims, and respond to and comply with court proceedings and orders on the Plan's behalf;

(k) Prepare, approve and execute other supporting documents which are necessary or appropriate for the operation of the Plan and on the Plan's behalf, including, without limitation, plan descriptions, insurance contracts, and contracts with service-providers.

(l) Research, hire and fire, negotiate terms with, manage the relationship with, and authorize payments to insurance companies, recordkeepers, administrators, claims processors, legal, accounting, actuarial, computer services and consulting firms and other vendors, which are necessary or appropriate for the operation of the Plan;

(m) Exercise all other powers given to the Committee under other Sections of the Plan.

5.3 **Allocation or Delegation of Duties and Responsibilities**. The Committee and the Board may:

(a) Employ agents to carry out nonfiduciary responsibilities.

(b) Delegate fiduciary responsibilities (other than trustee responsibilities as defined in Section 405(c)(3) of ERISA) to persons or entities other than their members under the rules of the next Section.

(c) Consult with counsel, who may be of counsel to the Company.

(d) Allocate fiduciary responsibilities (other than trustee responsibilities as defined in Section 405(c)(3) of ERISA) among their members under the rules of the next Section.

(e) Designate one or more individuals to have responsibility for designing and implementing administrative procedures for the Plan.

5.4 **Procedure for the Allocation or Delegation of Fiduciary Duties**.

(a) Any allocation or delegation of fiduciary responsibilities must be approved by majority vote, in a resolution approved by a majority of the Board.

(b) Delegation or allocation of fiduciary responsibilities may be changed or ended only under the rules of (a).

(c) Any delegation or allocation may include the power to subdelegate without further recourse to the Committee or Board.

5.5 **Finality of Decisions**. The Committee shall have full power, authority and discretion to enforce, construe, interpret and administer the Plan. All decisions and determinations of the Committee with respect to any matter hereunder shall be conclusive and binding on Eligible Employees and all other interested parties.

5.6 **Extension of Time Periods**. For good cause shown, the Committee may extend any period set forth in the Plan for taking any action required of any Participant or Spouse or Dependent to the extent permitted by law.

5.7 **Indemnification**. The Company agrees to indemnify and reimburse, to the fullest extent permitted by law, the Board, the Committee, and Employees acting for the Company, as well as former Committee members and former Employees, for any and all expenses, liabilities, or losses arising out of any act or omission relating to the rendition of services for or the management and administration of the Plan, except in instances of gross misconduct or willful breach of duty to the Plan.

ARTICLE VI

TERMINATION AND AMENDMENT

6.1 **Termination**. The Company, through action of the Committee, may terminate the Plan or any benefits offered under the Plan at any time.

6.2 **Amendment**. The Company, through action of the Committee, may amend the Plan at any time and in any respect.

6.3 **No Vested Benefits**. No Benefit under this Plan is nonforfeitable or vested, and termination or amendment under this Article VI, or by another authorized change in Benefits, may change or eliminate any Benefit even though payments under the existing provisions may have commenced or receipt of the Benefit was relied upon in connection with any arrangement that may have involved employee choices or release of other rights.

ARTICLE VII

CLAIMS PROCEDURE

7.1 **Establishment of Procedures**. The Committee shall establish procedures for the administration of claims under the Plan and shall have the authority to appoint, remove, and replace one or more Claim Administrators. Claims procedures set forth herein shall not apply to the extent that claims and appeals procedures are set forth differently in a Benefit Program incorporated herein, except to the extent that claims and appeals procedures set forth in a Benefit Program herein fail to comply with requirements of applicable law, in which case the provisions of this Article VII shall govern. The procedures for submission of claims, internal and external appeals and parties to whom payments shall be made are set forth in the applicable Benefit Program. In addition, the provisions of this Article VII shall not be interpreted so as to override applicable state laws that are more protective of Participants rights with respect to claims and appeals under ERISA plans, to the extent such state laws are not preempted by ERISA.

7.2 **Decision on the Claim**. The following rules shall apply to medical claims filed under the Plan.

(a) Urgent Care Claims - Claims for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or, in the judgment of a physician, would subject the patient to severe pain that cannot be adequately managed otherwise.

The Claim Administrator shall notify the claimant of the Plan's determination not later than **72** hours after receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claim Administrator shall notify the claimant as soon as possible, but not later than **24** hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than **48** hours, to provide the specified information. The Claim Administrator shall notify the claimant of the Plan's benefit determination as soon as possible, but no later than **48** hours after the earlier of the Plan's receipt of the specified information or the end of the period afforded the claimant to provide the specified additional information.

(b) Pre-service Claims – Claims which must be decided before a patient shall be afforded access to health care (e.g., preauthorization requests).

The Claim Administrator shall notify the claimant of the Plan's determination not later than **15** days after receipt of the claim. This period may be extended by **15** days, provided the Claim Administrator or its delegate determines that an extension is necessary due to matters beyond the control of the Plan and notifies the claimant within the initial period of the circumstances requiring the extension and the date by which the Plan expects to render a decision. If such an extension is necessary due to the claimant's failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information. If the claim is improperly filed, the Claim Administrator shall notify the

claimant as soon as possible, but not later than **5** days after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded at least **45** days from receipt of the notice within which to provide the specified information.

(c) Post-service Claims – Claims involving the payment or reimbursement of costs for medical care which has already been provided.

For non-urgent post-service health claims, the Plan has up to **30** days, to evaluate and process claims for benefits covered by ERISA. The **30**-day period begins on the date the claim is first filed. This period may be extended by **15** days provided the Claim Administrator or its delegate determines that an extension is necessary due to matters beyond the control of the Plan and notifies the claimant within the initial period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision. In addition, the notice of extension must include the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. The claimant shall be afforded at least **45** days from receipt of the notice within which to provide the specified information.

(d) Concurrent Care Claims – Claims where the Plan has previously approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments.

Concurrent care claims may fall under any of the other three categories, depending on when the appeal is made. However, the Plan must give the claimant sufficient advance notice to appeal the claim before a concurrent care decision takes effect.

(e) Notification of Denial - applicable to all health claims

An "adverse benefit determination" is a denial, reduction or termination of a benefit, failure to provide or pay for (in whole or in part) a benefit, a denial to participate in the Plan, or a claim denial on the grounds that the treatment is experimental, investigational or not medically necessary. This also includes concurrent care determinations. Certain retroactive terminations of coverage shall be considered adverse benefit determinations, whether or not there is an adverse effect on any particular benefit at that time, to the extent required by the Patient Protection Affordable Care Act ("ACA"), as amended by the Health Care and Education Reconciliation Act of 2010 ("HCERA"), and as interpreted by applicable guidance and regulations from the relevant government agencies. In the event of an adverse benefit determination, the claimant shall receive notice of the determination. If a claim is denied, in whole or in part, the claimant shall be notified of the denial in writing. The notice of denial shall contain the following information:

(1) The specific reason(s) for the denial;

(2) A reference to the specific provision(s) in the Plan on which the denial is based;

(3) A description of additional material or information necessary to perfect the claim and an explanation of why the material or information is needed;

(4) A description of the Plan's claim and appeal procedures and applicable timeframes;

(5) A statement of the claimant's right to bring a civil action under Section 502(a) of ERISA after the Plan's appeal procedure (set forth below) has been exhausted;

(6) If any internal rules, guidelines, protocols or similar criteria were used as a basis for the denial, either the specific rule, guideline, protocol, or other similar criteria or a statement that a copy of such information shall be made available free of charge upon request;

(7) For denials based on medical necessity, experimental treatment, or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation shall be provided free of charge upon request; and

(8) For adverse determinations involving urgent care, the notice shall also include a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than **3** days after the oral notice and

(9) Information sufficient to identify the claim; and

(10) A description of the Plan's standard used in denying the claim (for example, a description of the "medical necessity" standard may be included).

7.3 **Right to Appeal**. A claimant whose claim for benefits under the Plan has been denied, in whole or in part, shall have the right to appeal the denial.

(a) A claimant who has had a medical claim wholly or partially denied by the Claim Administrator or is otherwise adversely affected by action of the Claim Administrator, shall have the right to request review of the claim by contacting the Claims Administrator for the applicable Benefit Program. Such request must be in writing and must be made within **180** days after such claimant is advised of the Claim Administrator's action unless a longer period of time to file an appeal is permitted under the applicable Benefit Program. If written request for review is not made within the **180**-day period, or such longer period of time as permitted under the applicable Benefit Program, the claimant shall forfeit his or her right to review. The claimant or a duly authorized representative of the claimant may review all relevant information and submit issues and comments in writing.

The Claim Administrator or its delegate, as applicable, shall then review the claim. It shall issue a written decision reaffirming, modifying, or setting aside its former action within a reasonable period of time, but not later than:

(1) For urgent health claims, as soon as possible considering the medical situation, but no later than **72** hours,

(2) For pre-service claims, within a reasonable period of time given the medical situation, but no later than **30** days (or **15** days following each appeal if there are two mandatory appeals),

(3) For post-service claims, within a reasonable period of time, but not later than **60** days after receipt of the request for review (or **30** days following each appeal if there are two mandatory appeals).

A copy of the review determination shall be furnished to the claimant. If the claim is denied, the review determination notice shall contain the following information:

(A) The specific reason(s) for the denial;

(B) A reference to the specific provision(s) in the Plan on which the denial is based;

(C) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access and copies of all relevant information;

(D) A statement of the claimant's right to bring a civil action under Section 502(a) of ERISA;

(E) A description of any voluntary appeals procedures offered by the Plan, if any;

(F) A statement that the claimant has the right to obtain information about the voluntary appeals process, if any, and information as to how the claimant may obtain information about alternative dispute resolution options from the Department of Labor or state regulators;

(G) If any internal rules, guidelines, protocols or similar criteria were used as a basis for the denial, either the specific rule, guideline, protocol, or other similar criteria or a statement that a copy of such information shall be made available free of charge upon request;

(H) For denials based on medical necessity, experimental treatment, or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation shall be provided free of charge upon request;

(I) For adverse determinations involving urgent care, the notice shall also include a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than **3** days after the oral notice;

(J) Information sufficient to identify the claim;

(K) A description of the Plan's standard used in denying the claim (for example, a description of the "medical necessity" standard may be included); and

(L) Instructions for filing a second-level appeal as provided for under an applicable Benefit Program.

If an internal appeal of a medical claim involves an urgent care claim, such that the timeframe for completing an appeal would seriously jeopardize the life or health or the individual, such individual may initiate an external review at the same time as the internal appeal.

(b) Second Level Appeal

If a claimant is not satisfied with a first-level appeal decision, and the claimant is notified that there is a second level appeal process under the applicable Benefit Program, then the claimant shall file a second-level appeal before a panel of physicians and/or other health care professionals, as determined under the applicable Benefit Program, who were not involved in the original and first-level appeal decisions.

The decision on the second-level appeal shall be rendered in accordance with the terms of the applicable Benefit Program. Any written notice of denial shall include instructions for filing an external appeal.

(c) Additional Considerations

If a claimant files an internal appeal for medical benefits, such individual shall continue to be covered, pending the outcome of the internal appeal. This means that the Plan shall not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

For medical claims filed after January 1, 2014, if the Plan fails to strictly adhere to all of the requirements of the internal claims and appeals process for a claim, the claimant is deemed to have exhausted the internal process, and may begin an external review request immediately, regardless of whether the Plan or issuer asserts that it substantially complied with these requirements or that the error was de minimis, unless the Plan can demonstrate certain additional non-prejudicial factors under applicable law.

The Claims Administrator shall ensure that all claims and internal appeals for Medical benefits are handled impartially. The Claims Administrator shall ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual shall support a denial of benefits. The Claims Administrator shall ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

The Plan shall provide for the identification of experts whose advice was obtained on behalf of Plan in connection with an adverse determination, without regard to whether the advice was relied on in making determination.

In deciding an appeal of any adverse benefit determination based in whole or in part on a medical judgment, the Claims Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and such individual shall not have been consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual. In deciding an appeal, no deference shall be afforded to the initial adverse benefit determination and the review of the appeal shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual.

In connection with an internal appeal of a medical claim, a claimant shall be able to review his or her file and present information as part of the review. Before making a benefit determination on review, the Claims Administrator shall provide the claimant with any new or additional evidence considered or generated by the Plan, as well as any new or additional rationale to be used in reaching the decision. The claimant shall be given this information in advance of the date on which the notice of final appeal decision is made to give such claimant a reasonable opportunity to respond.

The decision shall be final and binding upon the claimant and all other persons or entities involved, except to the extent that the Plan provides for a voluntary appeals procedure subsequent to this appeals process, or the decision is subject to judicial review.

7.4 **Right to an External Review of Claims**.

To the extent required by ACA, as amended by HCERA, and as interpreted by applicable guidance and regulations from the relevant government agencies, the following rules shall apply to claims filed for benefits under the Plan. This Section 7.4 shall not be interpreted to give claimants any rights to external review beyond what is expressly required under PPACA, as amended by HCERA, and as interpreted by applicable guidance and regulations from the relevant government agencies.

Except as otherwise stated below, the claimant may request an external review of his or her claim denial within sixty business days from receipt of the decision on a second-level appeal or within sixty business days from the last date of the filing of an appeal in which the Claims Administrator failed to meet a required time-frame (unless a different time period for filing a request for an external review is provided under an applicable Benefit Program and is in accordance with applicable law). The external review process does not apply to an adverse benefit determination or to a final internal appeal of an adverse benefit determination that relates to a Participant's or Spouse or Dependent's failure to meet the requirements for eligibility under the terms of the Plan (for example, worker classification and similar issues). External review is not automatic; it must be requested by the claimant within the applicable timeframe and the claims must complete the required forms to request review. The external review shall be conducted in accordance with the applicable federal or state external review process under

applicable law (e.g., an Independent Utilization Review Organization ("IURO") assigned by the Department of Banking and Insurance).

7.5 **Discretionary Authorization**.

Inframark, as the Sponsor of the Wrap Plan, and all underlying Welfare Benefit Programs as identified in **Appendix A**, acknowledges that the authority to make claims decisions is frequently delegated to various parties under the terms of each program. Nevertheless, to the extent any benefits are denied, after the formal review, appeal and final denial of any self-insured benefits, Inframark nevertheless reserves the right to voluntarily provide such benefits, within its discretion, based upon the circumstances and equities of each situation. The rights reserved herein do not impair the ability of all fiduciaries to independently make all claims decisions and shall not overturn the decisions for any insured programs. Rather, as noted above, the intent of this provision is solely to allow for the discretionary payment of benefits determined not to be payable, when Inframark voluntarily believes it is equitable to provide denied benefits. Notwithstanding any provisions to the contrary, this Section 7.5 shall not apply unless Inframark amends the Plan in the future to retain the discretion provided in this provision.

ARTICLE VIII

HIPAA REQUIREMENTS

8.1 **Scope**. The provisions of this Article VIII shall apply to the medical benefits under the Plan.

8.2 **Definitions**. For purposes of this Article VIII, the following terms have the following meanings:

(a) "Business Associate" means an entity or person who (i) performs or assists in performing a Plan function or activity involving the use and disclosure of PHI (such as claims processing or administration, data analysis, underwriting, etc.); or (ii) provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves furnishing the service provider access to PHI.

(b) "Covered Entity" means a group health plan (including an employer plan, Insurer, HMO and government coverage such as Medicare); a health care provider (such as a doctor, hospital or pharmacy) that electronically transmits any health information in connection with a transaction for which the U.S. Department of Health and Human Services has established an electronic data interchange standard; and a health care clearinghouse (an entity that translates electronic information between nonstandard and HIPAA standard transactions).

(c) "Protected Health Information or PHI" means information that is created or received by the Plan. The information must also identify the participant, or there must be a reasonable basis to believe the information could be used (alone or in combination with other information) to identify the participant. The information must also relate to: (i) the past, present, or future physical or mental health or condition of a covered individual, (ii) the provision of the health care to a covered individual; or (iii) the past, present, or future payment for the health care of a covered individual.

8.3 **Uses and Disclosures of PHI**.

The Plan and the Company may disclose a Covered Employee's PHI or ePHI to the Company (or to the agent of the Company) for the plan administration functions under 45 CFR 164.504(a), to the extent not inconsistent with the HIPAA regulations. The Plan shall not disclose PHI or ePHI to the Company except upon receipt of a certification by the Company that the Plan incorporates the agreements of Sections 8.4 and 8.5, except as otherwise permitted or required by law.

8.4 **Privacy Agreements of the Company**

As a condition for obtaining PHI from the Plan and its Business Associates the Company agrees it shall:

(a) Not use or further disclose such PHI other than as permitted by Section 8.3, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;

(b) Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to the Company with respect to such information;

(c) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;

(d) Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Company becomes aware;

(e) Make the PHI of a particular participant available for purposes of the participant's requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA regulation 45 CFR 164.524 and 164.526;

(f) Make the PHI of a particular participant available for purposes of required accounting of disclosures by the Company pursuant to the participant's request for such an accounting in accordance with HIPAA regulation 45 CFR 164.528;

(g) Make the Company's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

(h) If feasible, return or destroy all PHI received from the Plan that the Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Company agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(i) Ensure that there is adequate separation between the Plan and the Company by implementing the terms of subparagraphs (1) through (3), below:

(1) Employees With Access to PHI: The employees, classes of former employees or other individuals under the control of the Company as identified in any separate **Exhibits**, as periodically updated by the Company, are the only individuals that may access PHI received from the Plan.

(2) Use Limited to Plan Administration: The access to and use of PHI by the individuals described in (1), above, is limited to plan administration functions as defined in HIPAA Regulation 45 CFR 164.504(a) that are performed by the Company for the Plan.

(3) Mechanism for Resolving Noncompliance: If the Company or the persons listed in the **Exhibits** determine that any person described in (1), above, has violated any of the restrictions of this Article VIII, then such individual shall be disciplined in accordance with the policies of the Company established for purposes of privacy and security compliance, up to and including dismissal from employment. The Company shall arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

Notwithstanding the foregoing, the terms of this Article VIII shall not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made pursuant to 45 CFR 164.504(f)(1)(ii) or (iii); of PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations.

8.5 **Security Agreements of the Company**

As a condition of obtaining e-PHI from the Plan, its Business Associates, Insurers and/or HMOs, the Company agrees it shall:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that the adequate separation between the Plan and the Company as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;

(d) Promptly report to the Plan in writing any successful security incident of which it becomes aware. For purposes of this Amendment, a successful security incident shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the e-PHI; and

Upon request from the Plan, the Company agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to the Company.

ARTICLE IX

MISCELLANEOUS PROVISIONS

9.1 **Notices**. Participants shall be responsible for furnishing the Company and Committee with current addresses for mailing notices, reports and benefit payments. Notice shall be deemed effective if directed to such addresses and mailed by first class mail.

9.2 **Reliance on Data**. The Company and Committee may rely on any data provided by a Participant, including representations as to age, health and marital status. Such representation shall be binding on any party seeking to claim a benefit through a Participant, and the Company and Committee shall have no obligation to inquire into the accuracy of any representation made at any time by a Participant.

9.3 **No Guarantee**. The Company and Committee have no obligation to maintain the benefits under this Plan.

9.4 **No Employment Rights**. Nothing in this Plan shall be deemed to confer upon any Employee any right to be retained in the service of the Company or to interfere with the right of the Company to otherwise deal with their Employees without regard to the existence of the Plan.

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

9.6 **Number of Plans for Purposes of ERISA and Code**. In general, this Plan shall be a single plan for purposes of ERISA and the Code. However, the Committee may divide the Plan into two or more separate plans for such purposes, with each such plan being governed by the terms of this Plan document.

9.7 **Subrogation**. If a Participant or Spouse or Dependent (a "Recipient") becomes entitled to or receives Plan benefits for any injury, illness or other loss and as a result becomes entitled to damages or other compensation, the Plan shall be entitled to such funds to the extent of Plan benefits payable to the Recipient. This Section applies to amounts received by insurance, litigation, settlement or other recovery ("Recipients Recovery"). This is so even if the Recipient's Recovery was payable in respect of types of losses not covered by this Plan (for example, pain and suffering, punitive damages, legal fees or costs, and/or lost wages). The Plan may make its reimbursement by constructive trust, equitable lien, right of subrogation, reimbursement, or any other equitable or legal remedy. The Plan has first priority with respect to the Recipient's Recovery. The Plan shall not be required to pay any expenses incurred by the Recipient in obtaining the Recipient's Recovery (such as attorney fees and other legal expenses). This Section applies even if the Recipient would not be fully compensated or otherwise made whole for the injury, illness, or other loss. Neither the common-fund doctrine nor the make-whole doctrine applies to this Plan. If a Recipient fails to comply with the provisions of this Section (or obtains benefits in excessive amounts), then the Plan shall have the additional right to terminate benefit payments and/or recover the reimbursement due to the Plan by offsetting

against future Plan benefits payable to or with respect to such Recipient. The Plan shall also have the right in any proceeding at law or equity to assert a constructive trust, equitable lien, or any other equitable or legal remedy or recover, against any and all persons that have assets that the Plan can claim rights to. Any amounts received by the Plan under this Section shall be applied to pay for benefits of Participants and Beneficiaries at large, even if doing so would reduce the amount of contributions made by the Company.

9.8 **Controlling Documents**. This Wrap Plan encompasses numerous Welfare Benefit Plans in accordance with various Plan documents, Booklets, Highlights and other materials. To the extent any Welfare Benefit Plan incorporated into this Plan is not a Health Plan, the health-related provisions of the Wrap Plan document shall not apply. Furthermore, to the extent that the provisions of any documents incorporated into this Wrap Plan are in conflict with the Wrap Plan, the controlling document shall be determined, based upon the content of the issue to be resolved, within the discretion of the Committee.

9.9 **Headings**. The headings and subheading in this Plan have been inserted for convenience of reference only. In the event of conflict between a heading and the content of a Section, the content of the Section shall control.

9.10 **Governing Law**. The provisions of the Plan shall be construed and enforced according to the laws of the Commonwealth of Pennsylvania, except to the extent such laws are superseded by the provisions of ERISA.

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

EMPLOYER:

INFRAMARK, LLC

By:_____

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