# Vermeer Manufacturing Company

## Formal Record of Action

Having full power and authority to bind the Company, the following actions are hereby taken by the undersigned representative of Vermeer Manufacturing Company (the "Company"), who is authorized to amend and modify the Company's employee welfare benefits plans on behalf of the Company, in its capacity as settlor of the Vermeer Manufacturing Health and Welfare Benefit Plan (the "Plan").

With respect to the amendment and restatement of the formal plan document and summary plan description for the Plan, the following resolutions are hereby adopted:

**RESOLVED:** That the plan document and summary plan description for the Plan be amended and restated effective 01/01/2026, in the form attached hereto, which formal plan document and summary plan description is hereby adopted and approved;

**RESOLVED FURTHER:** That the human resources department employees of the Company be, and they hereby are, authorized and directed to take any and all actions and execute and deliver such documents as they may deem necessary, appropriate or convenient to give effect to the foregoing resolutions including, without limitation, causing to be prepared and filed such reports, documents or other information as may be required under applicable law.

Dated: 1.19.26, but effective as stated above.

Signed:
Name: ~~Teresa Hovell~~ Kate Guest
Title: ~~Benefits Manager~~ VP, HR

# Vermeer Manufacturing Health and Welfare Benefit Plan

## Plan Document and Summary Plan Description

01/01/2026

# Table of Contents

# 1. Introduction

Vermeer Manufacturing Company (the "Plan Sponsor") established the plan of welfare benefits now collectively known as the Vermeer Manufacturing Health and Welfare Benefit Plan (the "Plan") effective 03/01/1987. The Plan has been amended from time to time, and it is hereby amended and restated in its entirety effective as of 01/01/2026 (the "Effective Date"). This restatement of the plan document and summary plan description for the Plan supersedes all previous plan documents and summary plan descriptions of the Plan. This restatement of the Plan is not intended to be a historical document; it does not reflect plan terms existing prior to the Effective Date. If you wish to see the plan terms applicable on a date prior to the Effective Date, please contact the Plan Administrator.

The Plan is intended to qualify as a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") for the benefit of employees of the Plan Sponsor and such other entities that adopt the Plan with the consent of the Plan Sponsor (the Plan Sponsor and such other participating employers in their capacities as non-fiduciary settlors of the Plan, collectively, the "Company"). This document, together with the Benefits Documents (defined below), is intended to comply with both the plan document and summary plan description ("SPD") requirements of ERISA.

The Company also provides certain benefits that are not subject to ERISA. The non-ERISA benefits provided by the Company include the following: Contributions to health savings accounts (HSA Contribution Account), Dependent care assistance account (dependent care FSA), Self-insured short-term disability, Pre-Tax Premium Benefit.

Reference is made to those non-ERISA benefits to establish that certain terms and conditions of the Plan also apply to the non-ERISA benefits of the Company—in particular Articles 3, 4, 6 and 8 and Sections 11.5. through 11.18. Such references to or reproduction of the Company's non-ERISA benefits in the plan document and SPD are for the convenience of Plan Participants and the Company, and the Company does not intend that such non-ERISA benefits become subject to ERISA. To the contrary, the Company intends that such benefits remain exempt from ERISA.

The Plan provides many different types of benefits, each of which has its own terms, conditions and procedures. For insured benefit types, the terms, conditions and procedures are as stated in the applicable insurance policy, which may include a policy certificate, application and other documentation as determined by the insurer of such policy. For self-insured benefit types, the terms, conditions and procedures are as stated in the applicable booklet, summary or other documentation as determined by the claims administrator of such self-insured benefit. Collectively, these documents are referred to herein as "Benefits Documents."

Please note: the Benefits Documents for the benefits provided under the Plan are an integral part of the plan document and SPD. This document should not be distributed without all exhibits, appendices and Benefits Documents; similarly, the Benefits Documents should not be distributed without this

document. If you have received this document without any one or more Benefits Documents, contact the Plan Administrator as soon as possible to obtain any missing Benefits Documents.

Except as expressly provided herein, in the event of a conflict between the terms of this document and the terms of a Benefits Document, the terms of this document shall control.

## 2. General Plan Information

**Plan Sponsor:** Vermeer Manufacturing Company
% Human Resources
1210 Vermeer Road East
Pella, Iowa 50251
Telephone: 641-628-3141
Federal employer identification number: 42-0663191

**Additional Participating Employers:** HDD Broker, LLC; Vermeer MV Solutions; Vermeer Underground Technology, Inc.

**Plan Administrator:** Vermeer Manufacturing Company (but only to the extent it is acting in its capacity as named fiduciary and plan administrator)
% Human Resources
1210 Vermeer Road East
Pella, Iowa 50251
Telephone: 641-628-3141

**Plan Number:** 501

**Plan Year:** 12 calendar month period ending December 31

**Agent for Service of Legal Process:** chief officer of the Plan Sponsor; service may also be made upon the Plan Administrator or a Trustee, if any

**Benefits Provided under the Plan:** all Company-sponsored welfare benefits subject to ERISA, but specifically excluding benefits provided under the Vermeer Manufacturing Company Welfare Benefits Plan for Part-Time Employees

**Period of Coverage for Benefits Elections:** January 1 - December 31

# 3. Eligibility for Participation

## 3.1. Eligible Employee

### 3.1.1. General Rules

You are an "Eligible Employee" if you are treated as an employee on the payroll records of the Company and are credited with at least 30 hours of service per week, on average, determined in accordance with the policies and procedures of the Plan Administrator. As used in this subsection, "employee" includes a partner to the extent the Company is a partnership for federal income tax purposes.

However, you are not an "Eligible Employee" if you are any of the following:

- Covered by a collective bargaining agreement (except to the extent that the collective bargaining agreement provides for participation in the Plan).
- A leased employee (that is, an employee of another employer leased to the Company).
- An employee having seasonal or temporary status on the books and records of the Company. Without limiting the discretion of the Company with respect to the foregoing, a temporary employee is generally one whose full-time work assignment is scheduled to last 4 months or fewer.
- A non-resident alien who received no U.S. earned income.
- An independent contractor.
- A Reclassified Employee. A "Reclassified Employee" is any person the Company does not treat as a common law employee (including, but not limited to, independent contractors, persons the Company pays outside of its payroll system and out-sourced workers) for federal income tax withholding purposes under Code Section 3401(a), whether by mistake or otherwise, and irrespective of whether there is a binding determination that the individual is an employee or a leased employee of the Company.

### 3.1.2. Newly Hired Employees

Newly hired Eligible Employees may enroll as Participants in the Plan and become eligible for benefits on the first day of the month following date of hire (that is, the first day of work for pay with the Company as an Eligible Employee), provided all enrollment processes are fully and timely completed, as directed by the Plan Administrator.

Eligible Employees automatically become Participants in the Pre-Tax Premium Benefit on the date such Eligible Employee becomes eligible to receive the benefits for which they are making pre-tax premium contributions.

### 3.1.3. Rehired Employees

If the employment of an Eligible Employee is terminated and such individual is subsequently reemployed by the Company as an Eligible Employee, then any such rehired Eligible Employee will be eligible to participate on the same terms and condition as an otherwise newly hired Eligible Employee, including satisfaction of the Plan's then-applicable waiting period.

If the employment of an Eligible Employee is terminated and such individual is subsequently reemployed by the Company but such individual is not an Eligible Employee upon rehire, then the rehired employee will be eligible to participate if/when the individual later does become an Eligible Employee, and at that time such individual may participate in the Plan as would an otherwise newly hired Eligible Employee, including satisfaction of the then-applicable waiting period.

Rehired Eligible Employees may make enrollment elections and become Participants as provided in Section 4.4.

### 3.1.4. Transitional Retirees

Transitional Retirement is a continuation of benefits under the Plan. "Transitional Retirement," for purposes of this Section, means the 12-month period after which you either (i) attain age 55 and are credited with 10 consecutive years of service with the Company, or (ii) attain age 65 and are credited with 5 consecutive years of service with the Company. Eligibility on account of Transitional Retirement applies only with respect to the Plan benefits in which you were enrolled immediately prior to your Transitional Retirement period. The election to continue Plan benefits during Transitional Retirement must be made at the time of Transitional Retirement, in accordance with the instructions of the Plan Administrator. Failure to elect Transitional Retirement continuation coverage for any one or more Plan benefits results in loss of eligibility on account of Transitional Retirement for such benefit(s), and an Eligible Employee in Transitional Retirement cannot later enroll in such benefit(s). To be eligible for benefit(s) under this Section, you must have been an Eligible Employee immediately prior to Transitional Retirement.

## 3.2. Eligible Dependents

For welfare benefits that provide dependent coverage, the following dependents are eligible as beneficiaries of the Plan ("Eligible Dependents"):

- An Eligible Employee's legal spouse, including a common law spouse. Common law marital status shall be determined by the Plan Administrator in accordance with the Plan Administrator's policies and procedures and in accordance with the laws of the state of the Eligible Employee's residence.

- A child of an Eligible Employee who is a resident of the United States and is age 25 or younger, or who is 26 or older, unmarried, is medically certified as disabled and is dependent on the parent. The term "child" means (i) a natural child, (ii) a stepchild, (iii) a legally adopted child, (iv) a child placed for adoption, (v) a child for whom the Eligible Employee is a party in a suit seeking adoption, (vi) a child for whom legal guardianship has been awarded to the Eligible Employee or the Eligible Employee's legal spouse, (vii) a child (within the meaning of (i)-(vi) above) of the Eligible Employee for whom and to the extent that health care coverage is required to be provided by the Eligible Employee through a Qualified Medical Child Support Order approved by the Plan Administrator.

An Eligible Dependent does not include dependent grandchildren unless specifically indicated above. An Eligible Dependent also does not include anyone who is also a Participant with respect to the same Plan benefit. No one can be an Eligible Dependent of more than one Eligible Employee. An Eligible Employee must be covered first in order to cover any Eligible Dependents. No Eligible Dependent shall be covered prior to the date the Eligible Employee becomes a Participant. The Eligible Employee must reimburse the Plan for any benefits paid for a spouse or a child at a time when the spouse or child did not satisfy the conditions of being an Eligible Dependent.

### 3.3. Eligible Retirees

Notwithstanding any Plan terms to the contrary, Eligible Retirees shall be deemed Eligible Employees with respect to the benefit(s) in which they were enrolled immediately prior to separation from service with the Company, and any provision of the Benefits Documents requiring active employment shall be disregarded.

For purposes of this subsection, "Eligible Retirees" shall mean a former Eligible Employee who (i) has separated from service with the Company; (ii) was a Participant in the Plan immediately prior to separation from service; (iii) has attained age 55 as of the date of Participant's separation; (iv) has accumulated, as of the date of Participant's separation, 10 years of continuous service with the Company, determined in accordance with the policies and procedures of the Plan Administrator, and (v) has not reached age 65. Without limiting a Participant's ability to continue benefit(s) under Section 3.1.4, once an Eligible Retiree reaches age 65, they will no longer be an Eligible Retiree Participant under this Section.

For welfare benefits of the Plan that provide dependent coverage, the Eligible Retiree's Eligible Dependents shall not be eligible for benefits under this Section.

Notwithstanding the foregoing, and notwithstanding the use of the terms, "lifetime" or "for life," there are no vested benefits provided by the Plan. The Plan Sponsor may amend, modify, or terminate the Plan or any component benefit, including any retiree coverage, at any time, with or without notice.

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## 4 Eligible Medicare Supplement Retirees

For purposes of this Section, "Eligible Medicare Supplement Retirees" shall mean a former Eligible Employee who (i) has separated from service with the Company; (ii) was a Participant in the Plan immediately prior to separation from service; (iii) has attained age 55 as of the date of Participant's separation; (iv) has accumulated, as of the date of Participant's separation, 10 years of continuous service with the Company, determined in accordance with the policies and procedures of the Plan Administrator, (v) is eligible for Medicare Parts A and B; and (vi) is entitled to (i.e., has enrolled in) Medicare Parts A and B.

An Eligible Dependent spouse shall be eligible to participate in the Medicare Supplement program provided that such spouse (i) is otherwise an Eligible Dependent; (ii) is eligible for Medicare Parts A and B; and (vi) is entitled to (i.e., has enrolled in) Medicare Parts A and B. Eligibility for spousal coverage is contingent upon the Eligible Medicare Supplement Retiree meeting the criteria outlined in this Section.

Individuals who enroll in a Medicare Advantage Plan (also known as Medicare Part C) or any other Medicare private health plan (including but not limited to HMOs, PPOs, or Private Fee-for-Service plans) are not eligible for benefits under this Section. This Plan will not provide "wrap-around" coverage, secondary payment, or reimbursement for copayments, coinsurance, or deductibles incurred under a Medicare Advantage Plan. In the event a Participant elects to enroll in a Medicare Advantage Plan, coverage under this Section shall be automatically suspended as of the effective date of the Medicare Advantage enrollment.

The Plan Administrator reserves the right to request a Medicare card or other proof of enrollment upon request. Notwithstanding the foregoing, and notwithstanding the use of the terms, "lifetime" or "for life," there are no vested benefits provided by the Plan. The Plan Sponsor may amend, modify, or terminate the Plan or any component benefit, including any retiree coverage, at any time, with or without notice.

## 3.5. Termination of Participation

You will stop being a Participant eligible to receive benefits from the Plan on the date you are no longer an Eligible Employee or the date your employment with the Company terminates, whichever occurs first. Eligible Dependents will cease to be beneficiaries of the Plan on the date that the Eligible Employee through whom the Eligible Dependent is receiving benefits terminates employment or otherwise ceases to be an Eligible Employee, or the date the dependent ceases to be an Eligible Dependent. To the extent provided in an applicable Benefit Document or established policy of the Plan Administrator, coverage under one or more Plan benefits will extend to the end of the month in which loss of eligibility occurs. When required by an applicable Benefit Document, coverage of an Eligible Dependent child will extend to the end of the year in which the child turns age 26, which extension may apply to other Plan benefits in accordance with established policy of the Plan Administrator.

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# 6 Special Eligibility Rules

### 3.6.1. Eligibility for Individual Welfare Benefits

Once eligibility for the Plan as a whole is established, eligibility for the individual welfare benefits provided under the Benefits Documents shall be determined by the Benefits Documents and any special eligibility rules set forth below. Certain welfare benefits of the Plan may have eligibility requirements in addition to those stated herein.

### 3.6.2. Service Area-Based Eligibility

To the extent that certain benefit options provided under the Plan are provided through health maintenance organizations (HMOs), accountable care organizations (ACOs) or similar arrangements with specific geographic service areas, such as state-level or zip code-level service areas, Eligible Employees residing outside such service area are not eligible for that benefit option.

### 3.6.3. Cafeteria Benefits Eligibility

The cafeteria benefits of the Plan are provided in conformity with, and must comply with, Internal Revenue Code ("Code") Section 125, which imposes certain limits on participation in a cafeteria benefit plan. Excluded from participation in the cafeteria benefits provided under this Plan are any individuals who are treated as self-employed individuals (including a partner or member) and any individuals who own (or are deemed to own) more than 2 percent of the outstanding stock of the Company, if the Company is treated as an S corporation. Such excluded persons may receive welfare benefits under this Plan, but they must do so on an after-tax basis.

### 3.6.4. Retiree Medical Benefits

Eligible Retirees are eligible to participate in the major medical benefit options otherwise available to similarly-situated employees (e.g., who reside in the same state). Except as provided below with respect to retiree dental and vision benefits, Eligible Retirees are not eligible for any other benefit provided under this Plan.

### 3.6.5. Retiree Dental and Vision Benefits

Eligible Retirees who are active participants in the Plan's dental and/or vision benefits are eligible to participate in the dental and vision options otherwise available to similarly-situated employees (e.g., those who reside in the same state). Except as provided above with respect to retiree medical benefits, Eligible Retirees are not eligible for any other benefit provided under this Plan.

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### 7 Employee Duty to Advise of Changes that Affect Eligibility

Participation in the Plan, whether as an Eligible Employee or Eligible Dependent, is at all times expressly conditioned on such person's continuous satisfaction of the criteria for Eligible Employees or Eligible Dependents, as the case may be. In addition, entitlement to any benefit under the Plan is at all times expressly conditioned on such person's continuous satisfaction of the eligibility and participation requirements of the Benefits Document governing such Plan benefit, including any waiting or exclusionary periods.

Eligible Employees have a continuing, affirmative duty to inform the Plan Administrator of any changes that affect eligibility of the employee or the employee's dependents, both for the Plan in general and for each benefit under the Plan. No benefit shall be payable to or on behalf of any person, whether as a purported employee or dependent, at any time during which such person was not eligible for such benefit under the express terms of the Plan and the Benefits Documents, even if premiums are paid or contributions collected for such benefit. Collection of premiums or contributions shall not be deemed acceptance of any person's eligibility by the Company, the Plan Administrator or any insurer or third-party administrator.

## 4. Enrollment

### 4.1. Elections, Generally

Except as expressly provided herein or in a Benefits Document, Eligible Employees may make separate elections to participate or not in each of the different benefits provided under this Plan. Once properly and timely enrolled in any Plan component benefit, you are considered a "Participant."

### 4.2. Open Enrollment

Prior to the beginning of each Plan Year (or Period of Coverage, if different), at a time and for a duration established by the Plan Administrator, there is an open enrollment period in which you may elect benefit coverage and salary reduction contributions under the Plan. The Plan Administrator will provide written notice to Eligible Employees of the open enrollment period and the benefit types for which open enrollment is either active or passive. (The dates and enrollment types of such notice are incorporated into this document.)

With respect to benefits for which the Plan Administrator determines open enrollment is active, all Eligible Employees must properly complete open enrollment forms and/or complete the online enrollment process as directed by the Plan Administrator during each open enrollment period. If an Eligible Employee fails to timely and properly complete the enrollment process, then such Eligible

Employee shall be deemed to have elected to contribute $0 to account-based benefits for which an election is not made and waived participation in all benefits for which an election is not made.

With respect to benefits for which the Plan Administrator determines open enrollment is passive, if an Eligible Employee fails to timely and properly complete the enrollment process, such Eligible Employee shall be deemed to have continued all previous benefit coverage and salary reduction elections.

Benefit types for which the Plan Administrator does not provide notice of passive enrollment (and that are not automatic, as provided in Section 4.5. below) shall be deemed to have active enrollment.

## 4.3. Newly Eligible Employees

When you first become an Eligible Employee (whether by promotion to a benefits-eligible position, initial hire as an Eligible Employee or rehire as an Eligible Employee), at a time and for a duration established by the Plan Administrator, there is a new hire enrollment period in which you may elect benefit coverage under the Plan. The Plan Administrator will provide written notice to newly Eligible Employees of the new hire enrollment period. (The enrollment dates of such notice are incorporated into this document.) The paper enrollment forms must be properly completed and turned in (or if enrollment is online, the online enrollment process must be completed) by the deadline established by the Plan Administrator. Failure to properly and timely complete the enrollment process will be deemed a waiver of all coverages.

## 4.4. Rehired Employees

If the employment of an Eligible Employee is terminated and such individual is subsequently reemployed by the Company as an Eligible Employee within 30 days of termination of employment, then the Plan Administrator may automatically reinstate benefit elections for such rehired Eligible Employee. Otherwise, rehired Eligible Employees may make new elections to participate in the Plan on the terms and conditions applicable to otherwise newly hired Eligible Employees, including complete and timely submission of all enrollment and benefit elections paperwork and/or online processes, as directed by the Plan Administrator.

## 4.5. Automatic Enrollment

The Plan Administrator may elect to automatically enroll you in benefits that are 100% paid by the Company. You may unenroll from such benefits by giving written notice to the Plan Administrator within the applicable enrollment period specified by the Plan Administrator.

With respect to the Pre-Tax Premium Benefit, you are deemed to have elected to contribute the entire amount of any premiums payable by the Participant for welfare benefits eligible for pre-tax treatment in which you are enrolled unless you affirmatively elect otherwise by giving written notice to the Plan Administrator within the applicable enrollment period specified by the Plan Administrator. A

Participant's election for Pre-Tax Premium Benefits shall be automatically adjusted for any change in the cost of insurance pursuant to the terms of Treas. Reg. Section 1.125-4. Enrollment in a benefit that is eligible for pre-tax premium payment shall constitute acceptance by the employee of the corresponding reduction in pay.

## 4.6. Modification of Elections; Mid-Year Election Changes

Benefits chosen during enrollment periods are fixed for the Plan Year (or Period of Coverage, if different) and may not be changed mid-year unless the Eligible Employee experiences one of the Internal Revenue Service ("IRS") qualified change in status events or other permitted election change event described below.

If you have a change in status or other permitted election change event, you may change coverage tiers add a benefit you waived, unenroll from a benefit you were enrolled in or change a salary reduction election, so long as such change is consistent with the change in status or other event. With respect to salary reduction contribution elections to account-based cafeteria plan benefits, your new annual contribution amount(s) may not be less than the amount previously reimbursed at the time of the election change.

You must give notice of the requested benefit change within 60 days of the event, unless a longer period of time is specified below or in an applicable Benefit Document. After 60 days (or longer, if so specified), the next opportunity to change benefits elections is during the regular open enrollment period.

For newborn children, the newborn must be enrolled under the Plan within 60 days of birth (or such longer period as is specifically provided in an applicable Benefit Document), even if a coverage tier election change is not needed. Notwithstanding anything in the Benefits Documents to the contrary, coverage will not be provided, even for the special enrollment period, if the newborn child is not enrollec within that time.

### 4.6.1. Change in Status

An Eligible Employee, including a Participant, may revoke an election during a Period of Coverage and make a new election for the remaining portion of the period if, under the facts and circumstances: (i) a change in status described below occurs; (ii) the election change is on account of and corresponds with a change in status that affects eligibility for coverage under a qualified benefits plan; and (iii) the Eligible Employee notifies the Plan Administrator of the change in status within the applicable period. While you are free to notify the Plan Administrator in advance, elections may not be modified mid-year in advance of, or in anticipation of, a change in status; the change in status must have occurred before the election change will be effective.

- Legal Marital Status. Events that change a Participant's legal marital status, including marriage, death of spouse, divorce, annulment and legal separation (but only to the extent eligibility under the Plan or a component benefit of the Plan is affected).
- Number of Dependents. Events that change a Participant's number of dependents, including by birth, death, adoption and placement for adoption.
- Employment Status. Any of the following events that change the employment status of the Participant, the Participant's spouse, or the Participant's dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite and, to the extent permitted in Treas. Reg. Section 1.125-4, change in employment status resulting in gaining or losing eligibility under the Plan.
- Dependent Satisfies or Ceases to Satisfy Eligibility Requirements. Events that cause a Participant's dependent to satisfy or cease to satisfy eligibility requirements for coverage, such as on account of attainment of age.
- Residence. A change in the place of residence of the Participant, spouse or dependent that affects eligibility under the Plan generally or under a particular benefit option of the Plan.

### 4.6.2. Other Permitted Election Change Events

A Participant may also revoke an election during a Period of Coverage and make a new election for the remaining portion of the period if, under the facts and circumstances: (i) one of the events described below occurs; and (ii) the election change is on account of and corresponds with such event. Unless specifically noted below or in an applicable Benefit Document, you must notify the Plan Administrator within 30 days of such event to qualify for a mid-year election change.

- Judgment, Decree, or Order. A Participant may modify an election pursuant to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in ERISA Section 609) that requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant; provided that the modification changes the Participant's election to provide coverage for the child if the order requires coverage for the child under the Plan or cancels coverage for the child if the order requires the spouse, former spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided.
- Entitlement to or Loss of Medicare, Medicaid or CHIP. A Participant may modify an election for benefits attributable to a Company-sponsored accident or health plan if the Participant, spouse, or dependent becomes entitled to coverage under a state child health program (CHIP), Medicare or Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines). The Participant may make a prospective election change to cancel or reduce coverage of that Participant, spouse, or dependent under the accident or health plan. Corresponding rights to commence or increase benefits under the accident or health plan

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shall be granted in the case of loss of coverage under CHIP, M dicare or Medicaid or entitlement to premium assistance under Medicaid or CHIP, but only if the Eligible Employee enrolls within 60 days.

- HIPAA Special Enrollment Rights. If a Participant or a Participant's Eligible Dependent is entitled to special enrollment rights under a group health plan benefit (other than an excepted benefit, and other than in the event of loss of Medicaid or CHIP), as required by HIPAA, then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that (i) the election change corresponds with such HIPAA special enrollment rights and (ii) you notify the Plan Administrator within 30 days after your coverage ends (or such other period as is expressly provided for in the applicable Benefit Document).
- Other Cost or Coverage Changes. A Participant may modify an election for benefits as a result of changes in cost or coverage, including changes made under another employer's plan, pursuant to Treas. Reg. Section 1.125-4.
- COBRA. If the Eligible Employee or the Eligible Employee's Eligible Dependent becomes eligible for continuation coverage under the Company's group health plan as provided in Code Section 4980B or any similar state law, the Eligible Employee may elect to increase contributions to the Pre-Tax Premium Benefit under the Plan in order to pay for the continuation coverage.
- FMLA. A Participant taking leave under the FMLA may revoke an existing election of accident or health plan coverage and make such other election for the remaining portion of the Period of Coverage as may be provided for under the FMLA.
- Exchange/Marketplace Enrollment. A Participant is permitted to modify an election of coverage under a group health plan benefit due to the Participant's enrollment (or the Participant's Eligible Dependents' enrollment) in a qualified health plan offered through the health insurance marketplace (a/k/a federal or state exchange). In order to modify an election of coverage under a group health plan due to enrollment in a qualified health plan offered through the health insurance marketplace, the Participant (or the Participant's Eligible Dependent(s), as the case may be) must be eligible for a special enrollment period to enroll in a qualified health plan through the marketplace or during the marketplace's annual enrollment period. In addition, the modification of the election of coverage under the group health plan benefit must correspond to the Participant's intended enrollment (and/or the Participant's Eligible Dependents' intended enrollment, as the case may be) in a qualified health plan through a marketplace for new coverage that is effective no later than the day immediately following the last day of the original coverage that is revoked.

### 4.6.3. Plan Administrator Discretion

The Plan Administrator reserves the right to determine whether a Participant has experienced an event that would permit an election change under this section and whether the Participant's requested election change is consistent with such event. The Plan Administrator may request any additional

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information or documents it deems necessary to evaluate the request d election change. Also, if the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify any election in order to assure compliance with such requirements or limitations. Any act taken by the Plan Administrator under this subsection shall be carried out in a uniform and non-discriminatory manner.

#### 4.6.4. HSA Election Changes

Notwithstanding the foregoing, to the extent the Plan provides an HSA Contribution Account benefit, a Participant who elects to make contributions to the Participant's individually-owned HSA through the HSA Contribution Account may prospectively start, stop, increase or decrease the election at any time. The Plan Administrator may, in a uniform and nondiscriminatory manner, establish a procedure placing additional restrictions on HSA Contribution Account elections.

#### 4.6.5. Rules of Proration

##### 4.6.5.1. HSAs

Federal individual income tax law may place prorated limits on an individual's contributions to a health savings account ("HSA") when the HSA account holder has impermissible group health coverage for some portion of the calendar year. To the extent the Plan provides HSA Contribution Accounts, the Plan Administrator may, but is not required to, prorate an Eligible Employee's election to contribute to the HSA Contribution Account to accommodate the prorated HSA contribution limit.

Further, to the extent the Plan provides HSA Contribution Accounts, if the Company elects to contribute to a Participant's HSA Contribution Account and if a Participant enrolls mid-year or otherwise becomes a Participant mid-year in the Plan's HSA Contribution Account benefit as permitted by this Plan, then the maximum available employer contribution to such Participant's HSA Contribution Account shall be prorated according to the number of days remaining in the Period of Coverage.

##### 4.6.5.2. Healthcare FSA and Dependent Care FSA

To the extent the Plan provides General Purpose Healthcare FSA benefits, Limited Purpose Healthcare FSA benefits and/or Dependent Care FSA benefits, if a Participant enrolls in one of these cafeteria plan benefits mid-year or makes a permissible mid-year election change, then the maximum allowable annual contribution will not be prorated by the number of pay periods remaining in the Period of Coverage.

### 4.7. Enrollment Is a Material Representation by Employee

By participating in the Plan or any component benefit, the employee affirmatively represents and warrants that the employee and the employee's dependents are eligible for the Plan and each component benefit in which the employee is enrolled. Such representation is material, and the Plan

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Administrator may rely upon it to its detriment. To the extent passive nrollment is indicated above, the employee's continued participation in a benefit following open enrollment shall be deemed an affirmative representation of continued eligibility.

Failure of any person to satisfy the eligibility and participation requirements of the Plan (including those of any Benefits Document), whether for the employee or the employee's spouse or other dependents, shall constitute a material breach of the employee's representation, and to the fullest extent allowed by law coverage may be rescinded retroactively to the date such representation was first untrue, even if premiums or contributions are collected for such benefit.

# 5. Benefits

## 5.1. Welfare Benefits

The welfare benefits provided under this Plan include those benefit components listed on the Welfare Benefit Insurer/TPA Appendix, below. The Plan Sponsor (or Plan Administrator or its delegate on the Plan Sponsor's behalf in its capacity as settlor) may update or modify the Welfare Benefit Insurer/TPA Appendix from time to time, and such changes shall be deemed an amendment to this Plan.

### 5.1.1. Incorporation of Benefits Documents

This Plan incorporates the terms and Benefits Documents of all welfare benefits provided and/or administered by the providers listed on the Welfare Benefit Insurer/TPA Appendix and all insurers/administrators offering benefits under this Plan. You should receive separate Benefits Documents for each of the welfare benefit components under the Plan. In these separate Benefits Documents, you should find additional information about eligibility, benefits and employee/employer contributions for each of the separate welfare benefits.

The actual terms and conditions of the welfare benefits offered under this Plan are contained in separate, written documents governing each respective benefit. Each such separate Benefits Document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein.

While the entry date for the Plan overall is as described in Section 3.1., the start date for coverage under a particular Plan benefit shall be as stated in the applicable Benefit Document to the extent such Benefit Document provides for a later coverage start date.

When you become eligible to participate in the Plan, the Company will automatically deduct participant-paid premiums from your pay and enroll you in the welfare benefits you selected during the enrollment process. The deduction will be used to automatically pay participant-paid premiums for the welfare benefits provided under this Plan.

Except as expressly provided herein, in the event of a conflict between the terms of this document and the terms of a Benefits Document, the terms of this document shall control.

## 5.2. Cafeteria Plan Benefits

The cafeteria benefits provided by the Plan are intended to qualify as a cafeteria plan within the meaning of Code Section 125. The cafeteria benefits of the Plan provide for the pre-tax payment of premiums for group term life insurance within the meaning of Code Section 79 and accident and health insurance within the meaning of Code Section 106 (the "Pre-Tax Premium Benefit"), plus the following additional cafeteria benefits: Contributions to health savings accounts (HSA Contribution Account), Dependent care assistance account (dependent care FSA), Healthcare flexible spending arrangement (general purpose healthcare FSA), Dental/vision-only flexible spending arrangement (limited purpose healthcare FSA).

### 5.2.1. Pre-Tax Premium Benefit

The Pre-Tax Premium Benefit allows you to pay the premiums for certain benefits identified below on a pre-tax basis. "Contributions" to the Pre-Tax Premium Benefit consist of the payroll deductions made to cover such premiums, as explained in more detail below. You will be eligible to make contributions to the Pre-Tax Premium Benefit only if you are also eligible to participate in the Plan and are enrolled in the benefit for which you are making contributions. The Period of Coverage for the Pre-Tax Premium Benefit is January 1 through December 31.

When you become eligible to participate in the Pre-Tax Premium Benefit, the Plan will establish a notional, or hypothetical, account in the books and records of the Company in your name. Participants may each choose to receive their full compensation for any Period of Coverage in cash or to have a portion of such compensation applied by the Company toward the Pre-Tax Premium Benefit, as explained in more detail below. The notional, or hypothetical, account will be credited with amounts withheld from the Participant's Compensation and will be reduced by any payments made on your behalf for the employee-paid portion of premiums. However, the Plan Administrator will not direct the Company to pay any premium to the extent such payment exceeds the balance of a Participant's Pre-Tax Premium Benefit account. A Participant's election for Pre-Tax Premium Benefits shall be automatically adjusted for any change in the cost of premiums pursuant to the terms of Treas. Reg. Section 1.125-4.

The Pre-Tax Premium Benefit is intended to qualify under Code Sections 79 and 106(a) and shall be interpreted in a manner consistent with such Code sections. To the extent that coverage is provided in excess of the limit described in Code Section 79(a) (generally $50,000), the value of such coverage shall be paid on an after-tax basis—that is, by imputation of income and/or payment of premiums with after-tax dollars.

The Pre-Tax Premium Benefit may be used to pay premiums for the following Company-sponsored benefits: medical,, dental, and vision.

The Pre-Tax Premium Benefit cannot be used to pay premiums for the following: a spouse's employer's group medical, dental, vision or other benefits; individual health insurance (such as from a state or federal exchange or marketplace); voluntary life, long-term disability, short-term disability, pre-paid legal, accident, critical illness.

The amount of your contributions to and the premiums that may be paid from the Pre-Tax Premium Benefit shall not exceed the Employee-paid portion of premiums payable under the permissible welfare benefits specified above.

### 5.2.2. HSA Contribution Account

**This subsection applies only if "HSA Contribution Account" is indicated in Section 5.2,** in which case the Plan provides an HSA Contribution Account benefit, and the following terms and conditions apply:

The term, "HSA," refers to a health savings account described in Code Section 223, and it shall be interpreted in a manner consistent with such Code section. An HSA is owned by the individual benefitting from such account, and it is administered by a trustee selected by the individual; it is not established or maintained by the Company. This Plan permits Eligible Employees to make pre-tax salary reduction contributions to their individually-owned HSAs using the Plan's cafeteria plan as a funding vehicle. In addition, the Company may, but is not required to, make additional nonelective contributions through the Plan's cafeteria benefit to Eligible Employees' individually-owned HSAs. The ability to make pre-tax salary reduction contributions and receive any employer contributions to Eligible Employees' individually-owned HSAs is referred to as the "HSA Contribution Account."

If you are an Eligible Employee and have elected to participate in a high deductible health plan designated by the Company as being HSA-eligible and no other medical coverage that is impermissible under Code Section 223, you are eligible for and may further elect to participate in this HSA Contribution Account benefit. If you are eligible for and elect to participate in the HSA Contribution Account benefit, the Plan will establish a notional, or hypothetical, HSA Contribution Account in your name on the books and records of the Company. This account will be credited with your contributions and will be reduced by the amount of any funds forwarded to your HSA on your behalf.

The annual contribution for a Participant's HSA Contribution Account is equal to the annual benefit amount elected by the Participant; provided, however, that the Plan Administrator may, but is not required to, limit HSA contributions it makes on your behalf so as to not exceed the statutory maximum amount for HSA contributions applicable to your high deductible health plan coverage option (i.e., single or family) for the calendar year to which the contribution relates. In addition, the maximum annual contribution shall be reduced by any matching (or other) employer contribution made on your

behalf and prorated for the number of months in which the Participant is eligible to make or receive HSA contributions.

Your HSA Contribution Account benefit is limited to your account balance. The Plan Administrator shall not forward contributions to the HSA administrator to the extent the contribution being forwarded or payment to be made exceeds the balance of a Participant's HSA Contribution Account. The mandatory twelve month period of coverage under Code Section 125 shall not apply to this HSA Contribution Account benefit.

HSAs are individually-owned by their account holders, as aforesaid. Neither the Plan Administrator nor the Company are responsible for any Participant's compliance with Code Section 223 or the compliance of any Participant's individually-owned HSA. It is the responsibility of the Participant to ensure compliance with all applicable tax laws relating to the HSA. In no way shall the Company or the Plan Administrator be responsible for the adverse tax consequences suffered by any Participant or any Participant's spouse or other dependents on account of HSA contributions or distributions.

#### 5.2.2.1. Coordination of HSA with General Purpose Healthcare FSA

To the extent the Plan provides General Purpose Healthcare FSA benefits, coverage under the Plan's General Purpose Healthcare FSA is impermissible coverage for an HSA; participation in the General Purpose Healthcare FSA benefit, including during any applicable grace period, will make you ineligible for the HSA Contribution Account benefit.

### 5.2.3. Healthcare FSA

The Plan offers Healthcare FSA benefits. The remainder of this subsection 5.2.3. only applies to the extent the Plan provides Healthcare FSA benefits and may be disregarded if the Plan does not.

#### 5.2.3.1. Healthcare FSA Accounts

The healthcare flexible spending account ("Healthcare FSA") established under this section is intended to qualify as a health flexible spending arrangement under Code Sections 125, 105 and 106(a) and shall be interpreted in a manner consistent with such Code sections. The Period of Coverage for the Healthcare FSA benefit is January 1 through December 31.

When you become eligible to participate in the Plan and elect to participate in the Healthcare FSA benefit, a notional (or hypothetical) Healthcare FSA account will be established in your name on the books and records of the Company. Each Participant may choose to receive such Participant's full compensation for any Period of Coverage in cash or to have a portion of such compensation applied by the Company toward the Healthcare FSA. The Healthcare FSA will be credited with your contributions and will be reduced by any payments made on your behalf.

You will be entitled to receive reimbursement from this account for eligible expenses incurred by you or your dependents. This is true regardless of which major medical coverage tier you are enrolled in (e.g., employee-only, employee-plus-spouse, employee-plus-children, or family). You may receive reimbursement for eligible expenses incurred at a time when you are a Participant in the Plan's Healthcare FSA benefit.

The entire annual amount you elect to contribute for the Period of Coverage for the Healthcare FSA, less any reimbursements already disbursed, will be available for reimbursement. The maximum amount you may contribute each year is established by the Plan Sponsor and is generally announced during open enrollment prior to the start of the Period of Coverage, which for the 01/01/2026 Period of Coverage (January 1 to December 31) is $3400. Elections in excess of the established maximum will be automatically reduced to the applicable maximum. The minimum amount of your annual election is $1.

#### 5.2.3.2. Funds Available After Period of Coverage

Generally, Healthcare FSA funds that are unused at the end of a Period of Coverage are forfeited; however, this Plan provides a limited opportunity to use unused Healthcare FSA funds through a grace period feature. To the extent you have unused amounts remaining at the end of a Period of Coverage, you may continue to incur Healthcare FSA claims and receive reimbursement for the 2 1/2 month period immediately following such Period of Coverage, provided that you timely submit such claims. Healthcare FSA funds that are unused at the end of the grace period shall be forfeited.

#### 5.2.3.3. Expenses Eligible for Reimbursement from General Purpose Healthcare FSA

"Eligible expenses" for Healthcare FSAs designated by the Plan Administrator as "general purpose" (or that are given no designation) includes all medical expenses that you may deduct on your federal income tax return under Section 213(d) of the Code, although health insurance premiums are not an eligible expense for the General Purpose Healthcare FSA. (Instead, see subsection 5.2.1. entitled, "Pre-Tax Premium Benefit.") Also, "qualified long-term care services," as defined by Code Section 7702B(c), are not eligible expenses for purposes of the General Purpose Healthcare FSA.

You will not be reimbursed for any eligible expenses that are (i) not incurred in the current Period of Coverage (plus any applicable grace period provided above), (ii) incurred before or after you are eligible to participate in the Plan's Healthcare FSA component benefit, (iii) attributable to a tax deduction you take in a prior taxable year, or (iv) covered, paid or reimbursed from any other source, including other benefits provided by this Plan and individual policies you may own or have contributed to.

#### 5.2.3.4. Expenses Eligible for Reimbursement from Limited Purpose Healthcare FSA

"Eligible expenses" for Healthcare FSAs designated by the Plan Administrator as "limited purpose" Healthcare FSAs include only those dental and vision expenses that you may deduct on your federal income tax return under Section 213(d) of the Code, and that are sufficiently "permitted coverage" under Revenue Ruling 2004-45, although health insurance premiums are not an eligible expense for the Limited Purpose Healthcare FSA. (Instead, see subsection 5.2.1. entitled, "Pre-Tax Premium Benefit.") Also, "qualified long-term care services," as defined by Code Section 7702B(c), are not eligible expenses for purposes of the Limited Purpose Healthcare FSA.

You will not be reimbursed for any eligible expenses that are (i) not incurred in the current Period of Coverage (plus any applicable grace period provided above), (ii) incurred before or after you are eligible to participate in the Plan's Healthcare FSA component benefit, (iii) attributable to a tax deduction you take in a prior taxable year, or (iv) covered, paid or reimbursed from any other source, including other benefits provided by this Plan and individual policies you may own or have contributed to.

#### 5.2.3.5. Forfeitures

Except to the extent funds are available pursuant to a carryover or grace period expressly provided in subsection 5.2.3.2. above, any unused amounts remaining at the end of the Period of Coverage, once all claims have been timely received and processed, will be forfeited and become the property of the Company. In addition, if your employment is terminated or you otherwise lose eligibility to participate in the Healthcare FSA, any balance remaining in your account as of the date of termination or other loss of eligibility will be forfeited after all claims are paid. Unused contributions may not be carried over, cashed-out, or converted to any other taxable or nontaxable benefit.

### 5.2.4. Dependent Care FSA

The Plan offers Dependent Care FSA benefits. The remainder of this subsection 5.2.4. only applies to the extent the Plan provides Dependent Care FSA benefits and may be disregarded if the Plan does not.

#### 5.2.4.1. Dependent Care FSA Accounts

The account established under this section ("Dependent Care FSA") is intended to qualify as a dependent care assistance program under Code Section 129 and shall be interpreted in a manner consistent with such Code section. The Period of Coverage for the Dependent Care FSA is January 1 through December 31.

When you become eligible for and elect to participate in the Dependent Care FSA benefit, a notional, or hypothetical, account will be established in your name on the books and records of the Company. Each Participant may choose to receive such Participant's full compensation for any Period of Coverage in

cash or to have a portion of such compensation applied by the Company toward the Dependent Care FSA. This account will be credited with your contributions and will be reduced by any payments made on your behalf. However, the Plan Administrator will not reimburse such expenses to the extent the reimbursement exceeds the balance of a Participant's Dependent Care FSA.

The maximum amount of expense that may be contributed/reimbursed in any Period of Coverage is $7500. The minimum amount of your annual election is $1.

#### 5.2.4.2. Qualifying Dependent Care Expenses

You will be entitled to receive reimbursement from the Dependent Care FSA for qualifying dependent care assistance. "Qualifying dependent care assistance" means services that:

- relate to the care of a dependent who is under age 13, or a spouse or a dependent who lives with you and who is physically or mentally incapable of self-care;
- enable the Participant and the Participant's spouse (unless the Participant's spouse is physically or mentally incapable of self-care) to remain gainfully employed after the date of participation in the Dependent Care FSA during the Period of Coverage; and
- are performed in the Participant's home or outside the Participant's home for any qualifying individual who regularly spends at least eight hours per day in the Participant's household.

If the expenses are incurred for services provided by a dependent care center (i.e., a facility including a day camp) that provides care for more than six individuals (other than individuals residing at the facility) on a regular basis and receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

"Qualifying dependent care assistance" does not include amounts paid to:

- an individual with respect to whom a personal exemption is allowable under Code Section 151(c) to a Participant or that Participant's spouse;
- a Participant's spouse;
- a Participant's child (as defined in Code Section 152(f)(1)) who is under 19 years of age at the end of the year in which the expenses were incurred; or
- a parent of a Participant's child under age 13 (e.g., a former spouse who is the child's noncustodial parent).

Please contact the Plan Administrator before enrolling in the Dependent Care FSA benefit to confirm that the expenses for which you will seek reimbursement will be qualifying dependent care assistance.

You will not be reimbursed for any expenses that are (i) not incurred in the current Period of Coverage or applicable grace period, (ii) incurred before or after you are eligible to participate in the cafeteria benefit component, (iii) attributable to a tax credit you take for the same expenses, or (iv) covered, paid or reimbursed from any other source. For purposes of the Dependent Care FSA, "incurred" means the

time the qualifying dependent care services giving rise to the expense are furnished, not when the Participant is formally billed for, is charged for, or pays for such services.

You may be required to file Form 2441 with your personal federal income tax return to determine whether any part of your Dependent Care FSA is taxable. Please note that participation in the Dependent Care FSA may prevent you from taking a tax credit for the same expenses. You should consult with your professional tax/financial advisor to determine the consequences of your participation in the Dependent Care FSA.

#### 5.2.4.3. Funds Available After Period of Coverage

Dependent Care FSA funds that are unused at the end of a Period of Coverage, or that are unused at the time your participation in or eligibility for the Dependent Care FSA ends, are forfeited, as provided below.

#### 5.2.4.4. Funds Available After Termination of Participation

When participation in the Dependent Care FSA benefit ends (such as upon termination of employment), no new Dependent Care FSA claims may be incurred beyond the end of the month of termination and unused Dependent Care FSA funds are forfeited, except that Dependent Care FSA claims incurred prior to termination of participation may be submitted as provided in Section 7.2.

#### 5.2.4.5. Forfeitures; No Carryovers

Any unused amounts remaining in the Dependent Care FSA at the end of a Period of Coverage (plus applicable grace period, if any) may not be cashed-out or converted to any other taxable or nontaxable benefit. Such unused amounts shall be forfeited and remain the property of the Company. No carryovers are permitted.

### 5.2.5. Cafeteria Benefits Nondiscrimination Requirements

If you are a highly paid employee or an owner of the Company, federal law may impose limits on your eligibility to participate in one or more cafeteria benefit components and/or the benefits you may receive from a cafeteria benefit component. In particular, the Plan may not discriminate in favor of highly compensated employees (within the meaning of Code Section 125(e)) as to benefits provided under or eligibility to participate in any cafeteria benefit component; key employees (within the meaning of Code Section 416(i)(1)) may not receive more than 25% of the aggregate benefits provided for all Employees under the cafeteria benefit components of this Plan; and the Plan may not discriminate in favor of key employees (within the meaning of Code Section 416(i)(1)) as to benefits provided or eligibility to participate with respect to any group term life insurance offered under this Plan.

To the extent the Plan provides health flexible spending arrangement benefits, the Plan may not discr minate in favor of highly compensated employees (within the meaning of Code Section 105(h)(5))

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as to benefits provided or eligibility to participate with respect to such benefits. To the extent the Plan provides dependent care assistance program benefits under Code Section 129, the Plan may not discriminate in favor of highly compensated employees (within the meaning of Code Section 414(q)) as to benefits provided or eligibility to participate.

#### 5.2.6. Coordination of Cafeteria Benefits

All claims for cafeteria benefits that are covered by an insurance policy or self-insured group health benefit must first be made to the insurance company issuing such insurance policy or third-party administrator, as the case may be. An expense is not an eligible expense unless it is not reimbursable by any other benefit to which you may be entitled.

## 5.3. Other Fringe Benefits

The Plan does not offer other fringe benefits intended to qualify as fringe benefits under Code Section 132. The remainder of this Section 5.3. only applies to the extent the Plan provides Section 132 fringe benefits and may be disregarded if the Plan does not.

The Section 132 fringe benefits provided under this Plan include: none.

These Section 132 fringe benefits are not offered under or through the Plan's cafeteria plan; however, certain Plan terms will apply, as stated in Article 1. In addition, elections, enrollment and benefit claims are administered under terms and conditions similar to the Plan's cafeteria benefits. The Period of Coverage for the Plan's Section 132 fringe benefits is January 1 through December 31.

# 6. Contributions and Funding

## 6.1. Employee Contributions

Premiums for the various benefits provided under this Plan are the responsibility of the employee. Notwithstanding anything to the contrary contained herein, participation in the Plan and the payment of Plan benefits (whether attributable to Company contributions or employee contributions) shall be conditioned on a Participant's contributing to the Plan at such time and in such amounts as the Plan Administrator shall establish from time to time. The Plan Administrator may require that any such Participant contributions be made by payroll deduction.

## 6.2. Company Contributions

The Company may, in its sole discretion, make non-elective contributions or other contributions to the Plan on behalf of Participants to defray some or all of the cost of those benefits. Each year, prior to or during the annual enrollment period discussed above, the Company will provide written notice of the

coverage options and premium amounts borne by Participants for the various benefits provided by this Plan. Any such written notice shall be deemed an amendment to this Plan.

## 6.3. No Funding Required

Except as otherwise expressly required by law: (i) Any amount contributed by a Participant and/or the Company to provide benefits hereunder shall remain part of the general assets of the Company and all payments of benefits under the Plan shall be made out of the general assets of the Company or the insurer of an insured benefit; (ii) The Company shall have no obligation to set aside any funds, establish a trust or segregate any amounts for the purpose of making any benefit payments under this Plan; and (iii) No person shall have any rights to, or interest in, any account other than as expressly authorized in the Plan.

All Participant contributions, including contributions for COBRA continuation coverage and contributions made through the Plan's cafeteria benefit, are subject to the claims of the Company's creditors. Notwithstanding the use of the term "account" in any Plan communication or Benefits Document (e.g., "flexible spending account"), the Plan does not establish any separate bank or trust accounts or in any other way segregate such funds from the Company's general assets. All such "accounts" are notional and for the Company's internal record-keeping purposes only. To the extent the Company deposits funds with a third-party administrator, such third-party administrator is a mere claims-paying agent of the Company, and it does not secure any benefits promised under this Plan. All notional record-keeping accounts and all claims payment accounts (whether or not titled in the name of the Company) are subject to the claims of the Company's creditors. No employee, dependent, Participant or beneficiary (or any authorized representative of any of the foregoing) shall have any right to, or interest in, the assets of the Company.

## 6.4. Funding Policy

The Company shall have the right to enter into a contract with one or more insurers and/or third-party administrators (TPAs) for the purposes of providing any benefits under the Plan and to replace any of such providers. No employee contribution shall be allocable to stop-loss insurance, reinsurance or any similar risk mitigation mechanism. Such policies and all proceeds from the same shall not be assets of the Plan but shall be the property of, and shall be retained by, the Company.

Benefit payments made under the Plan for self-insured benefits and premiums paid for insured benefits shall be paid first with employee contributions; only after exhaustion of employee contributions will benefit payments for self-insured benefits or premiums for insured benefits be paid with Company contributions. Any dividends, rebates (including medical loss ratio rebates), retroactive rate adjustments, refunds or proceeds of demutualization (or anything similar) of any type or nature whatsoever that may become payable under or relate to any Benefits Document shall not be assets of the Plan but shall be the property of, and shall be retained by, the Company. Without limiting the

foregoing, to the extent the law requires the Plan to allocate or relate funds coming into the Plan from third parties (e.g., providers, vendors, insurance companies, claims administrators, etc.) to the source of Plan contributions, such receipts shall be allocable first to Company contributions and second, after exhaustion of Company contributions, to employee contributions.

The Company will not be liable for any loss or obligation relating to any insurance coverage. Such limitation shall include, but not be limited to, losses or obligations that pertain to the following: (i) Once an insured benefit is applied for or obtained, the Company will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Company; (ii) To the extent premium notices are received by the Company, the Company's liability for the payment of such premiums will be limited to such premiums and will not include liability for any other loss which results from such failure; (iii) When employment of an employee ends, the Company will have no liability to take any step to maintain any policy in force except as may be specifically required otherwise in this Plan, and the Company will not be liable for or responsible to see to the payment of any premium with respect to periods after employment ends.

# 7. Claims

## 7.1. Welfare Benefit Claims

This section shall apply **only if** the claims procedures for the insurance companies and third-party administrators listed on the Welfare Benefit Insurer/TPA Appendix do not comply with the requirements of ERISA Section 503 and then only to the extent ERISA Section 503 would apply to such benefit if it were offered as the sole benefit of the Plan. If ERISA Section 503 applies and the insurer or TPA does have a claims procedure that complies with the timing requirements of ERISA Section 503, then the claims procedure of that insurer/TPA shall apply. In no event shall ERISA Section 503 apply to non-ERISA benefits.

In the case of a benefit that is considered a non-excluded and non-excepted "group health plan," any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures, are described in the relevant Benefit Document for that benefit and are incorporated herein.

### 7.1.1. General Welfare Benefit Claims Procedures

You or any other person entitled to welfare benefits from this Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the applicable welfare benefit insurer or TPA in accordance with the insurer's/TPA's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable insurer/TPA of the welfare benefit. Any claim that does not relate to a specific welfare benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan

Administrator. Any claim must include all information and evidence that the welfare benefit insurer/TPA or Plan Administrator (the "Claim Reviewer") deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. If a claim is received, but there is not enough information to process the claim, you will be given an opportunity to provide the missing information.

A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim.

If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the applicable benefit insurer or TPA identifying such authorized representative and so long as you include such written designation with your claim or appeal. It is your responsibility to provide written notice of such designation; absent a written designation, the Plan Administrator (or its designate) is not obligated to process any claim or appeal from any party other than Eligible Employees and their Eligible Dependents and it has no duty to request such written designation. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of your medical condition may act as your authorized representative with or without prior notice, but only for so long as the medical exigency exists.

Please note: Designation of an authorized representative is separate and distinct from assignment of claims, rights or benefits. An assignment of benefits by a Participant shall not be recognized as a designation of the purported assignee as an authorized representative.

### 7.1.2. Timing of Notice of Claim

The Claim Reviewer will notify the Claimant of any benefit determination within a reasonable period of time but not later than the timeframe specified below depending on the type of claim.

#### 7.1.2.1. Timing - Group Health Benefit Claims

Group health benefit claims may involve urgent care, concurrent care claims, pre-service care claims or post-service claims. Each has different timeframes that may apply and is described generally below. Notwithstanding the foregoing, the timeframe for benefit determinations of group health benefit claims shall be determined as provided under DOL Reg. Section 2560.503-1(f)(2) to the extent such regulation or guidance issued relating to such regulation may permit a longer time for the Claim Reviewer. Whether a particular benefit is a "group health benefit" (or "group health plan benefit") will be determined by the Plan Administrator applying DOL Reg. Section 2560.503-1(m)(6).

- Urgent Care. The Claim Reviewer will notify the Claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Claim Reviewer, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such a failure, the Claim Reviewer will notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Claimant will 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 Reviewer will notify the Claimant of the determination as soon as possible, but in no case later than 48 hours after the earlier of (A) the Claim Reviewer's receipt of the specified information, or (B) the end of the period afforded the Claimant to provide the specified additional information.
- Concurrent Care. "Concurrent care" means a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments. The Claim Reviewer will notify a Claimant of any reduction or termination of a course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care that will be decided as soon as possible, taking into account the medical exigencies, and the Claim Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Claim Reviewer, provided that any such claim is made to the Claim Reviewer at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.
- Pre-Service Claims. The Claim Reviewer will notify the Claimant of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Claim Reviewer. This period may be extended one time by the Plan for up to 15 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Reviewer expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.
- Post-Service Claims. The Claim Reviewer will notify the Claimant of an adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the

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Claim Reviewer both determines that such an ex ension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

#### 7.1.2.2. Timing - Disability Claims

In the case of a claim for disability benefits, the Claim Reviewer will notify the Claimant of any adverse benefit determination within 45 days after receipt of the claim by the Claim Reviewer. This period may be extended by the Plan for up to 30 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Claim Reviewer determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claim Reviewer notifies the Claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. The notice of extension will specifically explain 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, and the Claimant will be afforded at least 45 days within which to provide the specified information.

#### 7.1.2.3. Timing - Other Welfare Benefit Claims

The Claim Reviewer will notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial review period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

### 7.1.3. Notice of Denied Claim

If a claim is wholly or partially denied, the Claim Reviewer will provide the Claimant with a notice identifying (i) the reason or reasons for such denial, (ii) the pertinent Plan provisions on which the denial is based, (iii) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (iv) an explanation of the steps that the Claimant must take if

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he wishes to appeal the denial including a statement tha the Claimant may bring a civil action under ERISA.

In addition to the above information, if it is a group health benefit claim or a claim for disability benefits, the following information must be included with the notice described above: (i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; (ii) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; (iii) an explanation of the basis for disagreeing with or not disagreeing with the views presented to the Claim Reviewer of health care professionals treating the Claimant or vocational professionals who evaluated the Claimant, the views of medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination, and (with respect to claims involving disability) any Social Security Administration disability determination presented by the Claimant to the Claim Reviewer; and (iv) a statement that the Claimant may request copies of relevant documents relied upon by the Claim Reviewer.

In addition, in the case of an adverse benefit determination of a group health benefit claim for urgent care, a description of the expedited review process applicable to such claims must be included with the notice described above and may be provided to the Claimant orally within the time frame described above, provided that a written or electronic notification is furnished to the Claimant not later than 3 days after the oral notification.

Notices of denied claims will be provided in a culturally and linguistically appropriate manner, to the extent required under ERISA Section 503 and its implementing regulations.

### 7.1.4. Appeal of Denied Claim

If a Claimant wishes to appeal the denial of a claim, the Claimant must file an appeal with the Claim Reviewer on or before the 180th day (or the 60th day in the case of a claim other than a group health benefit or a disability benefit) after the Claimant receives the Claim Reviewer's notice that the claim has been wholly or partially denied. The appeal must identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant will be provided, upon request and free of charge, documents and other information relevant to the denied claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Claim Reviewer will consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of

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the denial of benefits, and such other facts and circums ances as the Claim Reviewer may deem relevant. The Claimant will lose the right to appeal if the appeal is not timely made.

In considering the appeal of a group health benefit or a disability benefit, the Claim Reviewer will: (i) provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by or on behalf of 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; (ii) provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (iii) provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; (iv) provide that the health care professional engaged for purposes of a consultation will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and (v) in addition, in the case of a claim involving urgent care, provide for an expedited review process pursuant to which a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Claimant and all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

With respect to appeals of group health benefit and disability benefit claims: (i) The Claimant will be provided, free of charge, with any new or additional evidence considered relied upon or generated by the Plan in connection with the claim sufficiently in advance of the final adverse benefit determination to give the Claimant a reasonable opportunity to respond prior to that date; (ii) The Plan will also meet the conflict of interest requirements under ERISA Section 503 and its implementing regulations; and (iii) A description of available internal and external claims processes and information regarding how to initiate an appeal will be provided.

### 7.1.5. Notice of Denied Appeal

If an appeal is wholly or partially denied, the Claim Reviewer shall provide the Claimant with a notice identifying (i) the reason or reasons for such denial, (ii) the pertinent Plan provisions on which the denial is based, (iii) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (iv) a statement describing the Claimant's right to bring an action under Section 502(a) of ERISA. The determination rendered by the Claim Reviewer shall be binding upon all parties.

In addition, if the claim is under a Benefits Document providing group health or disability benefits, the denial notice shall include (i) notice of any applicable limitations period imposed by the Plan; (ii) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request; (iii) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (iv) a discussion of the decision including an explanation of the basis for disagreeing with or not disagreeing with the views presented to the Claim Reviewer of health care professionals treating the Claimant or vocational professionals who evaluated the Claimant, the views of medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination, any Social Security Administration disability determination presented by the Claimant to the Claim Reviewer.

Except as provided below for group health urgent care, pre-service and post-service claims, the Claim Reviewer will notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination (45 days in the case of a claim involving disability benefits). If the Claim Reviewer determines that an extension of time for processing is required, written notice of the extension will be furnished to the Claimant prior to the termination of the initial 60-day period (45 days in the case of a claim involving disability benefits). In no event will such extension exceed a period of 60 days from the end of the initial period (45 days in the case of a claim involving disability benefits). The extension notice will indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review. If the denied claim is under a Benefits Document providing group health or disability benefits, the timing of the Claim Reviewer's review shall be determined in accordance with DOL Reg. Section 2560.503-1(i)(2) and 560.503-1(i)(3) to the extent such regulation or guidance issued relating to such regulation permits a longer period of time.

- Urgent Care Claims. In the case of a claim involving urgent care, the requirements of DOL Reg. Section 2560.503-1(f)(2)(i) apply as provided in DOL Reg. Section 2590.715-2719(b)(2)(ii)(B) and any superseding guidance. The Claim Reviewer will notify the Claimant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an adverse benefit determination by the Plan.
- Pre-Service Claims. In the case of a pre-service claim, the Claim Reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time

appropriate to the medical circumstances. Such notification will be provided not later than 30 days after receipt by the plan of the Claimant's request for review of an adverse benefit determination.

- Post-Service Claims. The Claim Reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time. Such notification will be provided not later than 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination.

#### 7.1.6. Exhaustion of Administrative Processes Required

Before a suit can be filed in any court, Claimants must exhaust all remedies and processes provided by this Plan.

#### 7.1.7. Requests for External Review

To the extent the Plan is required under DOL Reg. Section 2590.715-2719(c)(1)(i) or (c)(1)(ii) to comply with a State external claims process that includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the plan or issuer will comply with the federal external claims process of DOL Reg. Section 2590.715-2719(c). To the extent the Plan is not required under DOL Reg. Section 2590.715-2719(c)(1)(i) or (c)(1)(ii) to comply with the State external claims process, then the plan or issuer must comply with the Federal external claims process of DOL Reg. Section 2590.715-2719(d) and any superseding guidance.

### 7.2. Cafeteria Benefits Claims

#### 7.2.1. General Provisions

These provisions apply to all cafeteria benefit claims. Additional claims and appeals procedures provided in this section will apply to certain types of cafeteria plan benefits in addition to these general provisions.

#### 7.2.1.1. Coverage Period Claims

Coverage period claims are incurred (meaning the service is provided or the good is purchased) during the Plan's then-current Period of Coverage, January 1 through December 31. You must submit claims incurred during the Period of Coverage for reimbursement within 74 days after the end of the applicable Period of Coverage. If your employment is terminated, you must submit claims for reimbursement within 90 days after termination of employment.

#### 7.2.1.2. Grace Period Claims

The Plan permits grace period claims only to the extent a grace period is provided in subsection 5.2.3. or 5.2.4. If provided for by the Plan, grace period claims are incurred during the 2 1/2 month period

immediately following the Period of Cov rage to which the grace period relates. Grace period claims are paid out of the balance remaining from the immediately prior Period of Coverage and must be received by the end of the grace period plus 30 days. Notwithstanding any grace period that may be provided by the Plan, if you terminate employment you must submit claims for reimbursement within 90 days after termination of employment.

#### 7.2.1.3. Documentation of Claims

Any claim for cafeteria benefits must include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merits of the claim. The Plan Administrator may request any additional information necessary to evaluate the claim.

#### 7.2.1.4. Payment Mechanics

To the extent that the Plan Administrator approves a claim, the Company may either (i) reimburse you, or (ii) pay the service provider directly. The Plan Administrator will pay claims at least once per year. The Plan Administrator may provide that payments/reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Period of Coverage will be reimbursed without regard to the minimum payment amount.

#### 7.2.1.5. Debit/Credit Cards

The Plan Administrator or its delegate may provide you with a debit, credit or other stored-value card for purposes of making purchases that may be reimbursed from your General Purpose Healthcare FSA, Limited Purpose Healthcare FSA or Dependent Care FSA, as the case may be. (For purposes of this subsection, the General Purpose Healthcare FSA, Limited Purpose Healthcare FSA and Dependent Care FSA are collectively referred to as "FSA.")

Each Participant issued a card shall certify that such card shall only be used for eligible expenses. (For the definition of "eligible expense(s)", refer to subsections 5.2.3 and 5.2.4 above.) The Participant shall also certify that any eligible expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits with respect to any eligible expense paid with the card.

Such card shall be issued upon the Participant's effective date of Participation. Such card shall be automatically canceled upon the end of the Participant's participation or the occurrence of an event that causes the Participant to no longer be eligible for FSA benefits.

Purchases by the cards shall be subject to substantiation by the FSA Claim Reviewer, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Claim Reviewer shall also follow the requirements set forth in IRS Revenue Ruling 2003-43 and IRS Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

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If such purchase is later determined by the Plan Administrator or its delegate to not qualify as an eligible expense, the Plan Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole: (i) repayment of the improper amount by the Participant; (ii) withholding the improper payment from the Participant's wages or other compensation to the extent not inconsistent with applicable federal or state law (iii) claims substitution or offset of future claims until the amount is repaid; or (iv) consistent with the Company's business practices, the Company may treat the amount as any other business indebtedness. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card. Additional terms and conditions may be imposed by the issuer of the card, with which the Participant shall comply as a condition of FSA benefit entitlement.

#### 7.2.1.6. Refunds/Indemnification

Because of the tax-qualified nature of the cafeteria benefits, you must immediately repay any excess payments/reimbursements or any payments/reimbursements that are taxable to you. You must reimburse the Company for any liability the Company may incur for making such payment, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

#### 7.2.1.7. Beneficiary

In the event of your death, your beneficiaries or your estate may submit cafeteria benefits claims for eligible expenses for the portion of the Period of Coverage preceding the date of your death. You may designate a specific beneficiary for this purpose (a "Beneficiary"). If you do not name a Beneficiary, the Plan Administrator, in its discretion, may pay any amount to your surviving spouse, one or more of your surviving dependents or a representative of your estate.

### 7.2.2. Pre-Tax Premium Benefits Claims

Contributions to the Pre-Tax Premium Benefit are automatically forwarded to the insurance carrier or TPA administering the benefit for which you are paying pre-tax premiums. Should you have questions or feel that you need to make a claim under the Pre-Tax Premium Benefit, contact the Plan Administrator. All claims for benefits paid through the Pre-Tax Premium Benefit that are covered by an insurance policy must first be made to the insurance company issuing such insurance policy.

### 7.2.3. HSA Contribution Account Claims

To the extent the Plan provides for contributions to a health savings account, contributions to the HSA Contribution Account are automatically forwarded to the proper party for administration. Should you have questions or feel that you need to make a claim under the HSA Contribution Account, contact the

Plan Administrator. Claims for reimburs ment from your own personal health savings account should be directed to the trustee of such account. Consult the documentation provided to you during account setup for details.

### 7.2.4. Healthcare FSA Claims

#### 7.2.4.1. Application for Benefits

You or any other person entitled to benefits from a Healthcare FSA (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan's Healthcare FSA claims administrator ("Claim Reviewer"):

Alerus Retirement and Benefits
201 East Clark Street,
Albert Lea, MN 56007
Phone: 877-661-4727
Website: alerusrb.com

Any Healthcare FSA claim application must include: (i) the person(s) on whose behalf the identified eligible expenses have been incurred; (ii) the nature and date of the expenses so incurred; (iii) the amount of the requested reimbursement; (iv) a statement that such expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and (v) other such details about the expenses that may be requested by the Claim Reviewer or Plan Administrator.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the eligible expenses have been incurred and showing the amounts of such expenses, along with any additional documentation that the Claim Reviewer may request. If the Healthcare FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with IRS Rev. Rul. 2003-43, IRS Notice 2006-69, or other IRS guidance.

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#### 7.2.4.2. Notice of Denied Claim

The Claim Reviewer shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall

specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

If a claim is wholly or partially denied, the Claim Reviewer shall provide the Claimant with a notice identifying (i) the reason or reasons for such denial, (ii) the pertinent Plan provisions on which the denial is based, (iii) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (iv) an explanation of the steps that the Claimant must take if the Claimant wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA, and (v) whether (A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol or other criterion will be provided free of charge to the Claimant upon request; or (B) if the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

#### 7.2.4.3. Appeal of Denied Claim

If a Claimant wishes to appeal the denial of a claim, the Claimant shall file an appeal with the Claim Reviewer on or before the 180th day after the Claimant receives the Plan Administrator's notice that the claim has been wholly or partially denied. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his or her claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Claim Reviewer shall consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Claim Reviewer or Plan Administrator may deem relevant. In considering the appeal, the Claim Reviewer shall:

- Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by or on behalf of 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;
- Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary (or its designate) shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

- Provide that the health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Claim Reviewer shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination. The Claimant shall lose the right to appeal if the appeal is not timely made.

#### 7.2.4.4. Denial of Appeal

If an appeal is wholly or partially denied, the Claim Reviewer shall provide the Claimant with a notice identifying (i) the reason(s) for such denial with a discussion of the decision, (ii) the pertinent Plan provisions on which the denial is based, (iii) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (iv) a statement describing the Claimant's right to bring an action under Section 502(a) of ERISA and the Claimant's right to the external appeals process. The determination rendered by the Claim Reviewer shall be binding upon all parties.

#### 7.2.4.5. Imputed Income for Denied or Unsubstantiated Claims

To the extent any payment for a Healthcare FSA claim has been paid or advanced (as in the case of Healthcare FSA credit/debit cards, for example) and such claim is later denied or deemed unsubstantiated, the Plan Administrator reserves the right to direct the Company to impute income to the Claimant and/or withhold additional taxes from the Claimant to recoup the taxable portion of such claim.

### 7.2.5. Dependent Care FSA Claims

To the extent the Plan provides Dependent Care FSA benefits, you or any other person entitled to benefits from the Dependent Care FSA (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan's Dependent Care FSA claims administrator ("Claim Reviewer"):

Alerus Retirement and Benefits
201 East Clark Street,
Albert Lea, MN 56007
Phone: 877-661-4727
Website: alerusrb.com

Any Dependent Care FSA claim must be in writing and must include all information and evidence that the Claim Reviewer deems necessary to properly evaluate the merits of and to make any necessary determinations on a claim for benefits. The Claim Reviewer or Plan Administrator may request any additional information necessary to evaluate the claim.

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To the extent any payment for a Dependent Care FSA claim has been paid or advanced (as in the case of Dependent Care FSA credit/debit cards, for example) and such claim is later denied or deemed unsubstantiated, the Plan Administrator reserves the right to direct the Employer to impute income to the Claimant and/or withhold additional taxes from the Claimant to recoup the taxable portion of such claim.

The Claim Reviewer shall notify the Claimant of any adverse benefit determination. If a dependent care claim is wholly or partially denied, the Claim Reviewer shall provide the Claimant with a written notice of such denial. If a Claimant wishes to appeal the denial of a dependent care claim, the Claimant shall file a written appeal with the Claim Reviewer on or before the 60th day after the Claimant receives the Claim Reviewer's written notice that the claim has been wholly or partially denied. The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to the claim. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Claim Reviewer shall consider the merits of the Claimant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Claim Reviewer or Plan Administrator may deem relevant. The Claimant shall lose the right to appeal if the appeal is not timely made. The Claim Reviewer shall ordinarily rule on an appeal within 60 days. However, if circumstances require an extension, the Claim Reviewer may take up to 120 days to rule on an appeal.

#### 7.2.6. All Other Cafeteria Benefits Claims

Claims for all other cafeteria benefits shall be made in accordance with the Benefits Documents governing such benefits.

# 8. Plan Administrator

## 8.1. Designation

The Plan Administrator shall be Vermeer Manufacturing Company, as stated in Article 2. The Plan Administrator shall also be the named fiduciary within the meaning of ERISA Section 402. If the Plan Sponsor designates a Committee as the Plan Administrator, the Committee shall consist of one or more individuals who may be employees appointed by the Plan Sponsor. The Committee may, but is not required to, elect a chairperson and adopt such rules and procedures as it deems desirable. The Committee may also take action with or without formal meetings and may authorize one or more individuals, who may or may not be members of the Committee, to execute documents on its behalf.

## 8.2. Authority and Responsibility of the Plan Administrator

The Plan Administrator shall be the Plan "administrator" as such term is defined in Section 3(16) of ERISA, and as such shall have total and complete discretionary power and authority:

- to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;
- to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits in accordance with the plan document and SPD for the Plan;
- to determine the amount and manner of any allocations hereunder;
- to maintain and preserve records relating to the Plan;
- to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;
- to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;
- to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;
- to determine all questions of the eligibility of employees and of the status of rights of Participants under the Plan;
- to determine the validity of any judicial order;
- to retain records on elections and waivers by Participants;
- to supply such information to any person as may be required;
- to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.

## 8.3. Procedures

The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished to it. The Plan Administrator's decisions shall be final, binding and conclusive as to all parties.

## 8.4. Allocation of Fiduciary Duties and Responsibilities

The Plan Administrator may delegate its authority and designate other persons to carry out any of its duties and responsibilities under the Plan.

A Plan fiduciary shall have only those specific powers, duties, responsibilities and obligations as are explicitly given it. To the fullest extent permitted by law, no fiduciary shall be responsible for any act or failure to act of another fiduciary. A fiduciary may serve in more than one fiduciary capacity with respect to the Plan.

## 8.5. Compensation and Expenses

The Plan Administrator shall serve without compensation for its services, though the Plan Administrator may compensate such claims administrators and other service providers as it deems appropriate.

All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the Company, including by use of amounts forfeited hereunder and, when permitted under ERISA, Plan assets.

## 8.6. Indemnification of the Plan Administrator

The Company shall indemnify and hold harmless any Company employee serving as or acting on behalf of the Plan Administrator from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan or ERISA.

## 8.7. Final Discretionary Authority

The Plan Administrator (or the benefit claims administrator or other delegate) shall perform its duties as the Plan Administrator and in its sole and absolute discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained.

The Plan Administrator shall have full and absolute authority to construe the terms of the Plan and all facts surrounding claims for benefits under the Plan and shall determine all questions arising in the administration, interpretation and application of the Plan, including, but not limited to, those concerning the determination of the usual and customary (U&C) charge and eligibility for benefits and reconciling any different provisions of the Plan, including, but not limited to, any other document made part of the Plan by reference. Notwithstanding any provision to the contrary and unless the Plan Administrator

determines otherwise, the provisions of the Plan shall prevail compared to any provision of any other document incorporated into the Plan by reference.

Accordingly, benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that an applicant is entitled to them. All determinations with respect to the Plan, any construction of the terms of this Plan and any determination of fact adopted by the Plan Administrator, or any benefits claims administrator or other person on the Plan Administrator's behalf, shall be final and legally binding on all parties. The Plan Administrator shall have the full authority to establish policies and procedures in administering any specific provision of the Plan, which policies and procedures may be uniform and nondiscriminatory as the circumstances require.

Any interpretation, determination or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole and absolute discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

As indicated above, this Plan incorporates the terms and Benefits Documents of all welfare benefits provided and/or administered by the providers listed on the Welfare Benefit Insurer/TPA Appendix and all insurers/administrators offering benefits under this Plan. This means that the discretionary authority of the Plan Administrator (or its fiduciary delegate) under this section to construe the terms of the Plan includes the discretionary authority to construe the terms of the Benefits Documents, which are part of the Plan notwithstanding that the Plan and/or such Benefits Documents also constitute summary plan descriptions under ERISA. Any interpretation of the terms of the Plan by the Plan Administrator or its fiduciary delegate (including any interpretation of ambiguous or other terms of the Benefits Documents that are part of the Plan) shall be binding upon all persons unless the Plan Administrator or its fiduciary delegate is determined to have abused its discretion. The rule of *contra proferentem* does not apply in interpreting ambiguous or other terms of the Plan or any Benefits Document. Therefore, the Plan Administrator or its fiduciary delegate shall not be considered to have abused its discretion or to have made a legally incorrect interpretation of the Plan because its interpretation is contrary to an interpretation that construes ambiguous provisions of Benefits Document in favor of a Participant, beneficiary or other claimant. A claim for benefits under the Plan shall be determined based on the terms of the Plan (including any Benefits Documents which are part of the Plan), without regard to whether such document satisfies any statutory requirement of ERISA or any other applicable law (including state insurance laws).

### 8.8. Records

Plan records shall be kept on the basis of the Plan Year (or Period of Coverage, if different). The Plan Administrator shall exercise such authority as it deems appropriate in order to comply with the terms of the Plan relating to the records of Participants and beneficiaries and the amounts that are payable under the Plan. The Plan Administrator shall to the extent administratively practicable make available to each Participant such of its records under the Plan as pertain to the Participant for examination at reasonable times as determined by the Plan Administrator.

## 9. Continuation Rights

### 9.1. COBRA and State Continuation

To the extent the Plan is subject to COBRA (Code Section 4980B) and/or other similar applicable state law, Participants and covered Eligible Dependents may in certain circumstances be entitled to continuation coverage, which is a temporary extension of coverage under the Plan. Please see the notice entitled, "COBRA Continuation Coverage Notice," that is attached to the end of this document for important information about the right to federal COBRA continuation coverage. The COBRA notice generally explains federal COBRA continuation coverage and when it may become available.

### 9.2. FMLA

To the extent the Plan is subject to the Family Medical Leave Act (FMLA), the Plan Administrator shall permit a Participant taking unpaid leave under the FMLA to continue medical benefits under such applicable law. Non-medical benefits shall be continued according to the established Company policy. Participants continuing participation pursuant to the foregoing shall pay for such coverage under a method as determined by the Plan Administrator satisfying Treas. Reg. Section 1.125-3 Q&A-3. Generally, though, and without limiting the applicability of Company policy or Plan Administrator discretion to interpret and administer such policies, Participants must pay for coverage in a manner consistent with their cafeteria benefits elections (that is, by pre-tax salary reduction) to the extent of any available paid leave and must pay for coverage on an after-tax basis thereafter. In the Plan Administrator's sole discretion, the Participant and the Company may establish a schedule to catch up on premium payments upon return from leave.

Any Participant on FMLA leave who revoked coverage shall be reinstated to the extent required by Treas. Reg. Section 1.125-3. If the Participant's coverage under the Plan terminates while the Participant is on FMLA leave, the Participant is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. Upon reinstatement into the Plan upon return from FMLA leave, the Participant has the right to (i) resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments, or (ii) resume coverage at a level that is

reduced by the amount of unpaid premiums and resume premium payments at the level in effect before the FMLA leave.

### 9.3. Non-FMLA Leave

Participants may elect to continue coverage on a pre-tax or after-tax basis when on an approved leave of absence **other than** leave that qualifies under FMLA only in accordance with Company policy. Generally, though, and without limiting the applicability of Company policy or the Plan Administrator's discretion to interpret and administer such policies, Participants must pay for coverage in a manner consistent with their cafeteria benefits elections to the extent of any available paid leave (that is, by pre-tax salary reduction) and must pay for coverage on an after-tax basis thereafter. In the Plan Administrator's sole discretion, the Participant and the Company may establish a schedule to catch up on premium payments upon return from leave.

### 9.4. Military Leave (USERRA)

Participants who serve in the United States Armed Forces and must miss work as a result of such service may be eligible to continue to receive benefits with respect to any qualified military service. The Plan Administrator shall permit Participants to continue benefit elections as required under the Uniformed Services Employment and Reemployment Rights Act and shall provide such reinstatement rights as required by such law. The Plan Administrator shall also permit Participants to continue benefit elections as required under any other applicable state law to the extent that such law is not preempted by federal law.

## 10. Your Rights Under ERISA

As a Participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). This federal law provides that you have the right to:

- 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 Employee Benefits Security Administration if a 5500 is required to be filed by the Plan.
- 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 Plan 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.

- If COBRA applies, 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 the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" 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 your benefits or exercising your rights under ERISA.

If your claim for a 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 the documents governing the Plan 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 $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan 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 medical 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.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

# 11. Miscellaneous

## 11.1. Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order ("QMCSO"). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

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

## 11.2. Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-relatec benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your Plan Administrator at the number provided in Article 2.

## 11.3. Newborns' And Mothers' Health Protection

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## 11.4. HIPAA Privacy Rules

Certain of the benefits provided under this Plan, if provided under separate plans, would be subject to HIPAA, while others would not be. For purposes of HIPAA, the Plan shall be designated as a "hybrid entity," as that term is defined under HIPAA, such that it shall be a covered entity only with respect to those benefit components of the Plan that would be non-excepted group health plan benefits if structured as separate plans. As a hybrid entity, this section shall apply only to the extent that a component benefit of this Plan constitutes a "group health plan" as defined in Section 2791(a)(2) of the Public Health Service Act. Furthermore, the group health plan component benefits of the Plan, together with any other group health plan benefits maintained by the Company, whether or not provided under this Plan, plus their business associates, insurers and third-party administrators, shall constitute a single "organized health care arrangement." As a hybrid entity and organized health care arrangement, the Plan is required under federal law to take sufficient steps to protect any protected health information.

### 11.4.1. General Requirements

The Plan shall adopt a HIPAA privacy policy, the terms of which are incorporated herein by reference. The Plan will enter into a business associate agreement with any persons as may be required by applicable law as determined by the Plan Administrator. The Plan will provide each Participant with a notice of privacy practices to the extent required by applicable law.

### 11.4.2. Disclosure to the Company and Plan Administrator

This subsection permits the Plan to disclose protected health information ("PHI"), as defined in the HIPAA privacy rules, to the Company or to the Plan Administrator under certain conditions. The Plan may disclose the PHI to the Company that is necessary for it to carry out the following administrative functions related to the Plan: underwriting and Plan amendments or termination, provided that such disclosures are consistent with the privacy obligations of this section. The Plan may disclose PHI to the Plan Administrator (or its delegates) that is necessary for it to carry out the following administrative functions related to the Plan: eligibility determinations; enrollment and disenrollment activities; and plan administration functions that the Plan Administrator performs, provided that such disclosures are consistent with the privacy obligations of this section.

### 11.4.3. Use and Disclosure Limitations

The Company and the Plan Administrator agree to the following limitations and requirements related to their use and disclosure of PHI received from the Plan:

- Neither the Company nor the Plan Administrator shall use or further disclose PHI other than as permitted or required by the documents governing the Plan or as required by all applicable law, including but not limited to the HIPAA privacy rules;
- When using or disclosing PHI or when requesting PHI from the Plan, the Company and Plan Administrator shall make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request;
- The Company and the Plan Administrator shall require any agents, including subcontractors, to whom they provide PHI received from the Plan to agree to the same restrictions and conditions that apply to the Company or the Plan Administrator, as the case may be, with respect to such information;
- Except as permitted by the HIPAA privacy rules and other applicable federal and state privacy laws, neither the Company nor the Plan Administrator shall use PHI for employment-related actions and decisions, or in connection with any other employee benefit plan of the Company;
- The Company and Plan Administrator shall promptly report to the Plan any improper use or disclosure of PHI of which it becomes aware;
- The Company shall provide adequate protection of PHI and separation between the Plan and the Company by: (i) ensuring that only those employees who work in the human resources department of the Company on issues related to the healthcare components of the Plan will have access to the PHI provided by the Plan; (ii) restricting access to and use of PHI to only the employees identified in clause (i) above and only for the administrative functions performed by the Plan Administrator on behalf of the Plan that are described herein; (iii) requiring any agents of the Plan who receive PHI to abide by the Plan's privacy rules; and (iv) using the Company's established disciplinary procedures to resolve issues of noncompliance by the employees identified in clause (i) above;
- The Company and the Plan having determined that the Company's destruction of PHI or return of PHI to the Plan is infeasible, the Company shall extend the protections of this section to PHI in its custody or control and limit further uses and disclosures of such PHI for so long as the Company maintains such PHI;
- The Company and Plan Administrator shall provide Participants with the following rights: (i) the right to access to their PHI in accordance with HHS Reg. Section 164.524; (ii) the right to amend their PHI upon request (or the Company or Plan Administrator will explain to the Participant in writing why the requested amendment was denied) and incorporate any such amendment into a Participant's PHI in accordance with HHS Reg. Section 164.526; and (iii) the right to an accounting of all disclosures of their PHI in accordance with HHS Reg. Section 164.528; and
- The Company and Plan Administrator shall make its books, records, and internal practices relating to the use and disclosure of PHI received from the Plan available to HHS for verification of the Plan's compliance with the HIPAA privacy rules.

### 11.4.4. Certification

By adopting the Plan, the Company hereby certifies that the Plan has been amended in accordance with HHS Reg. Section 164.504(f), and that the Company and Plan Administrator shall protect PHI as described herein.

### 11.4.5. Security Standards Requirement

To comply with the HIPAA security standards regulations, the Company and Plan Administrator must: (i) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan; (ii) ensure that the adequate separation required by HHS Reg. Section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures; (iii) 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; and (iv) report to the Plan any security incident of which it becomes aware.

### 11.4.6. HIPAA Privacy Amendments

Notwithstanding any other provision of the Plan, this section may be amended in any way and at any time by the privacy officer.

### 11.4.7. Appointment of Privacy Officer and Group Health Plan Representatives

The individual denoted below as the "privacy officer" shall be and hereby is named the privacy officer and security officer of the Plan. Furthermore, the Plan hereby recognizes and authorizes the following individuals to use and disclose PHI to the extent necessary for successful operation and administration of the Plan:

- Highest-ranking human resources officer/employee (privacy officer)
- Subordinate staff of the privacy officer

## 11.5. Non-Alienation of Benefits; Anti-Assignment

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, either before or after goods or services are provided, without the express, written consent of the Plan Administrator, except that you may designate a Beneficiary to receive payments in the event of your death.

No assignment of benefits shall be valid unless (i) the provider or other third-party assignee accepts the payment determined by the Plan Administrator or its claims administrator to be payable under the Plan

as payment in full for services rendered and (ii) the Plan Administrator has accepted the assignment in writing. Any payment for goods or services directly to a provider is for the administrative convenience of the Plan Participant or Beneficiary only and does not evidence acceptance of any purported assignment of benefits. Similarly, any treatment of a third party as a Participant's authorized representative is acceptance of that party as an authorized representative only; it shall not be deemed acceptance of any purported assignment of benefits to such third party.

The interest of any person under the Plan is not subject to the claims of such person's creditors (other than the Plan) and may not be voluntarily or involuntarily transferred, assigned, alienated, or encumbered (other than to or by the Plan) without the specific written consent of the Plan Administrator.

No current or former Participant shall at any time, either during the Participant's participation in the Plan, or following termination as a Participant, in any manner whatsoever have any right to assign any choses in action or rights to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which the Participant may have against the Plan or its fiduciaries.

No third-party rights are intended or granted by the plan document and SPD for the Plan. Nothing contained herein or in any Benefits Document shall be construed to make the Plan, the Plan Administrator or the Plan sponsor liable to any third party to whom a Participant may be liable for care, treatment or services.

## 11.6. Amendment

The Plan provides for no vesting of benefits. The Company may amend, modify, terminate or merge the Plan at any time and from time to time for any reason or no reason whatsoever, with or without notice, and any such amendment, modification, termination or merger may be retroactive.

## 11.7. Termination

It is the intention of the Plan Sponsor that this Plan will be indefinitely maintained. However, the Plan Sponsor reserves the right to terminate the Plan at any time for any reason or no reason at all. Each entity constituting the Company reserves the right to terminate its participation in this Plan. In addition, each such entity constituting the Company shall be deemed to terminate its participation in the Plan if: (i) it is a party to a merger in which it is not the surviving entity and the surviving entity is not an affiliate of another entity constituting the Company, or (ii) it sells all or substantially all of its assets to an entity that is not an affiliate of another entity constituting the Company. Upon termination, any assets remaining in the Plan shall be used to pay outstanding benefit claims, after which any assets then remaining shall revert to the Company to the maximum extent permitted by law (unless such reversion would be permissible but subject to special taxation, levy or assessment, in which case the Plan

Sponsor may elect to waive this clause). To the extent permitted by the Benefits Documents and to the extent the assets do not revert to the Company, any remaining assets shall be refunded to Participants.

## 11.8. Taxation

The Company intends that most benefits provided under the Plan will not be taxable to you under federal tax law. Further, the Company intends that your contributions not be subject to federal income tax or Social Security taxes, to the extent federal law allows. However, some jurisdictions may not recognize some relationships for preferential tax treatment. In such cases, the value of the benefits provided to these individuals will be added to the Employee's taxable income.

The Company does not represent or guarantee that any particular federal, state or local income, payroll personal property or other tax consequence will result from participation in this Plan. Also, please note that while you may enjoy certain tax benefits, there may be some drawbacks to participation in the cafeteria benefit component. For instance, participation may lower your social security benefits.

The plan document and summary plan description of the Plan is not intended to be, and should not be construed in any manner as giving, any tax or tax-related advice. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

## 11.9. Minor or Legally Incompetent Payee

If a distribution or claim payment is to be made to or on behalf of an individual who is either a minor or legally incompetent, the Plan Administrator may direct that such distribution be paid to the legal guardian. If a distribution or claim payment is to be made to a minor and there is no legal guardian, payment may be made to a parent of such minor or a responsible adult with whom the minor maintains residence, or to the custodian for such minor under the Uniform Transfer to Minors Act, if such is permitted by the laws of the state in which such minor resides. Such payment shall fully discharge the Plan Administrator and the Company from further liability on account thereof.

## 11.10. Missing Payee

If the Plan Administrator is unable to make payment to any Participant or to any healthcare provider on a Participant's behalf or to any other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant, healthcare provider or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant, healthcare provider or other person shall be forfeited one year after the date any such payment first became due.

## 11.11. Refunds; Indemnification

Because of the tax-qualified nature of the benefits provided under the Plan, you must immediately repay any excess payments/reimbursements or any payments/reimbursements that are taxable to you. Benefits of the Plan are conditioned on your reimbursing the Company for any liability the Company may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this benefit component.

## 11.12. Beneficiary

In the event of your death, the beneficiaries or your estate may submit claims for the portion of the Plan Year (or Period of Coverage, if different) preceding the date of your death, subject to the same limitations as other claims. You may designate a specific beneficiary for this purpose (a "Beneficiary"). If you do not name a Beneficiary, the Plan Administrator may, in its discretion, pay any amount to your spouse, one or more of your dependents or a representative of your estate.

## 11.13. Third Party Recovery

The Plan Administrator may, but is not required to, utilize the provisions of this section to the extent not inconsistent with the provisions of any applicable Benefits Document, in which case the provisions of the Benefits Document shall control.

### 11.13.1. In General

When a Participant or covered dependent receives Plan benefits which are related to medical expenses that are also payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, the Participant shall reimburse the Plan for the related Plan benefits received out of any funds or monies the Participant recovers from any third party.

### 11.13.2. Specific Requirements and Plan Rights

Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that a Participant or covered dependent may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the

recovery is structured or worded, and even if the Participant or covered dependent has not been paid or fully reimbursed for all of their damages or expenses.

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring the Participant to assert a claim to any of the benefits to which the Participant or a covered dependent may be entitled. The Plan will not pay attorneys' fees or costs associated with the claim or lawsuit without express written authorization from the Company.

If the Plan should become aware that a Participant or covered dependent has received a third-party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to the Participant and covered dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of the Participant or covered dependents.

### 11.13.3. Participant Duties and Actions

By participating in the Plan each Participant and covered dependent consents and agrees that a constrictive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, each Participant and covered dependent agrees to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once a Participant or covered dependent has any reason to believe that the Plan may be entitled to recovery from any third party, the Participant must notify the Plan. And, at that time, the Participant (and the Participant's attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Participant or covered dependent to any payment, amount or recovery from a third party.

If a Participant fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to the Participant or covered dependent until the agreement is signed. Alternatively, if a Participant fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of the Participant or a covered dependent, the Participant's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

Each Participant and covered dependent consents and agrees that they shall not assign their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

## 11.14. No Right to Employment

Nothing with respect to the Plan shall be construed as a contract of employment between the Company and the Participant, or as a right of any employee to continue in the employment of the Company, or as a limitation of the right of the Company to discharge any of its employees, with or without cause.

## 11.15. Governing Law; Venue

The Plan shall be construed in accordance with and governed by the laws of the Plan Sponsor's state of organization, but only to the extent not preempted by federal law. For any action arising out of or relating to the Plan or the benefits provided thereunder, venue and forum shall only be proper in the federal court in or nearest to the city of the Plan Sponsor's address above.

## 11.16. Severability of Provisions

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

## 11.17. Effect of Mistake

In the event of a mistake as to the eligibility or participation of an employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator may, but is not required, to the extent it deems practicable, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due the Plan or the Company from compensation paid by the Company.

## 11.18. Time Limits Absolute

To the extent this document or a Benefits Document fails to establish an outside time limit on the filing of any claim, such claim for benefits must be properly completed and filed within one year of the date of service for such claim. No benefits will be due or owing for claims submitted after that time.

Time is of the essence. The claim filing and appeals timelines of the Plan are absolute. No waiver by the Plan Administrator or its delegate is permitted. These time limitations (and the prohibition against waivers of such limitations) shall apply to participants/beneficiaries as well as to their successors, heirs, assigns, legal representatives, Medicare/CMS and any other person or entity whose rights are derivative of participants/beneficiaries.

Notices to the Company or the Plan Administrator (or any delegate of the Company or the Plan Administrator) are deemed given when actually received during business hours of the Company (or of the delegate, as the case may be). To the fullest extent allowed by law, any notice, election or action of an employee, dependent, Participant or beneficiary (or any authorized representative of any of the foregoing) must be given, made or taken during business hours of the Company. If a deadline provided or referenced herein or in a Benefit Document falls on a non-business day of the Company, then, to the extent allowed by law, such deadline shall fall on the immediately preceding business day.

## 11.19. Balance Billing Protections Are Not Plan Benefits

Federal or state law may provide certain rights or procedures for determining amounts payable to a provider, and such rights or procedures may have the effect of limiting how much the provider is permitted to charge a Participant or Beneficiary. In no event is any federal or state law protection against being charged for an amount in excess of the amount determined to be payable by the Plan (i.e., "balance billing" or "surprise billing" protection) a Plan benefit. Those procedures, and the exercise of those rights, are not Plan benefits, and the Plan makes no guaranty of any particular outcome of such procedures or rights. No statements, communications or notices concerning balance billing rights or procedures shall constitute a promise or guaranty of any particular result, and in no way shall the Plan be liable for any amount that is balance billed, whether or not any federal or state balance billing protection rights are fully or properly exercised or procedures are timely or properly followed.

# COBRA Continuation Coverage Notice

You are receiving this notice because you may be covered under the Vermeer Manufacturing Health and Welfare Benefit Plan (the "Plan"). This notice contains important information about rights you may have to COBRA continuation coverage ("COBRA coverage"), which is a temporary extension of group health coverage under the Plan in certain circumstances when coverage would otherwise end. This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). If COBRA applies to the Plan, COBRA coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

This notice is a summary only; it does not fully describe the COBRA coverage law or other rights or obligations under the Plan. For a more complete description of your rights and obligations concerning COBRA coverage, see the Plan's governing documents or contact the human resources department of the Company, whose contact information is below. The Plan provides no greater COBRA rights than what COBRA requires; nothing in this notice is intended to expand your rights beyond COBRA's requirements.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

**What Is COBRA Continuation Coverage?**

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event (and after any required notice is properly and timely provided to the Plan), COBRA requires that COBRA coverage be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries entitled to elect COBRA coverage if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA coverage must pay for COBRA coverage

If you are an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than gross misconduct.

If you are the spouse of an employee, you will be entitled to elect COBRA coverage if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than gross misconduct; or
- You become divorced or legally separated from your spouse.

A person enrolled as your dependent child will be entitled to elect COBRA coverage if such person loses group health coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than gross misconduct; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

**When Is COBRA Coverage Available?**

When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries.

**You Must Give Notice of Some Qualifying Events**

For all other qualifying events (including divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA coverage election will only be available if you notify the Plan in writing within 60 days after the later of (a) the date the qualifying event occurs or (b) the date on which the qualified beneficiary loses or would lose coverage under the terms of the Plan as a result of the qualifying event. If you do not timely and properly give notice you and your dependents will lose any rights to elect COBRA continuation coverage. Contact the Plan to obtain the appropriate forms for this notice, including a description of any required information or documentation.

**Electing COBRA Coverage**

Each qualified beneficiary will have an independent right to elect COBRA coverage. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA continuation coverage on behalf of their children. Any qualified beneficiary for whom COBRA coverage is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE THE RIGHT TO ELECT COBRA.

**How Long Does COBRA Coverage Last?**

COBRA coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, (death of the employee, a covered employee's divorce or legal separation, or losing eligibility as a child) may permit a beneficiary to receive up to 36 months of Plan group health coverage.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which employment terminates, COBRA coverage for the

employee's spouse and children who lost coverage as a result of the termination of employment can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination of employment or reduction in hours. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage periods described in this notice for several reasons, which are described in the Plan's summary plan description.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

1. Disability extension of COBRA coverage.

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you properly notify the Plan in a timely fashion, all qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

The disability extension is available only if you notify the COBRA administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of: (a) the date of the Social Security Administration's disability determination; (b) the date of the covered employee's termination of employment or reduction of hours; or (c) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. The COBRA administrator may require that notice be given on certain forms. Contact the COBRA administrator to obtain the proper forms. If the Plan's and COBRA administrator's procedures are not followed or if the notice is not provided to the COBRA administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

2. Second qualifying event extension of COBRA coverage.

If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction in hours (including COBRA coverage during a disability extension period), the spouse and dependent children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving COBRA coverage if the employee or former employee dies, gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare after termination of employment

or reduction of hours.) This extension due to a second qualifying event is available only if you notify the COBRA administrator in writing of the second qualifying event within 60 days of the date of the second qualifying event.

**Are There Other Coverage Options Besides COBRA Coverage?**

Yes. Instead of enrolling in COBRA coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA coverage. You can learn more about many of these options at www.healthcare.gov.

In addition, you may have continuation coverage rights under state law. For more information about state continuation coverage contact by mail at Paylocity, PO Box 7410397, Chicago, IL 60674-0397 or by phone at 800-631-3539.

**Can I Enroll in Medicare Instead of COBRA Coverage after My Health Plan Coverage Ends?**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

**If You Have Questions**

Questions concerning your Plan or your COBRA rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

**Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plar Administrator.

**Plan Contact Information**

| Plan Administrator: | COBRA Administrator: |
|---|---|
| Vermeer Manufacturing Company<br>% Benefits<br>1210 Vermeer Road East<br>Pella, Iowa 50251<br>Telephone: 641-628-3141 | Paylocity<br>PO Box 7410397,<br>Chicago, IL 60674-0397<br>Phone: 800-631-3539 |

# Vermeer Manufacturing Health and Welfare Benefit Plan

## Welfare Benefit Insurer/TPA Appendix

01/01/2026

| Benefit Type | Insurer or Third-Party Administrator | Administration | Funding |
|---|---|---|---|
| Medical | Wellmark BCBS of Iowa | Self-Insured | Unfunded |
| Prescription Drugs | Keenan Pharmacy through Express Scripts | Self-Insured | Unfunded |
| Vermeer Health Services Center (Limited On-Site Medical) | Premise Health | Self-Insured | Unfunded |
| Vermeer Family Pharmacy (Limited On-Site Prescription Drugs) | Walgreens through Premise Health | Self-Insured | Unfunded |
| Chronic Condition Management Services | Vermeer Health Services | Self-Insured | Unfunded |
| Telehealth | Dr. On Demand (Wellmark BCBS of Iowa) | Self-Insured | Unfunded |
| Dental | Delta Dental | Self-Insured | Unfunded |
| Vision | Avesis | Insured | Unfunded |
| Basic Life and Accidental Death & Dismemberment | Lincoln Financial | Insured | Unfunded |
| Voluntary Life | Lincoln Financial | Insured | Unfunded |
| Long-Term Disability | Lincoln Financial | Insured | Unfunded |
| Pre-Paid Legal | Legal Shield | Insured | Unfunded |
| Accident | Lincoln Financial | Insured | Unfunded |
| Critical Illness | Lincoln Financial | Insured | Unfunded |

| | | | |
|---|---|---|---|
| Statutory Leave (MN Paid Leave) | Lincoln Financial | Insured | Unfunded |
| Employee Assistance Program | Workplace & Family Life Services | Self-Insured | Unfunded |
| Wellness | Life Well Program | Self-Insured | Unfunded |
| Short-Term Disability (non-ERISA) | Vermeer | Self-Insured | Unfunded |
| General-Purpose Healthcare Flexible Spending Account | Alerus | Self-Insured | Unfunded |
| Limited-Purpose Healthcare Flexible Spending Account | Alerus | Self-Insured | Unfunded |
| Dependent Care Flexible Spending Account (non-ERISA) | Alerus | Self-Insured | Unfunded |
| HSA Contribution Account (non-ERISA) | Alerus | Self-Insured | Unfunded |