RIVIAN AND VW GROUP TECHNOLOGY, LLC WELFARE BENEFIT PLAN

Effective January 1, 2025

Table of Contents

Page

ARTICLE I ESTABLISHMENT AND PURPOSE 1
Section 1.01 Establishment 1
Section 1.02 Purpose 1
Section 1.03 Benefit Programs 1
Section 1.04 Annual Reporting Requirements 2
Section 1.05 Applicability of Plan 2
Section 1.06 Compliance with Applicable Law 2

ARTICLE II DEFINITIONS 3
Section 2.01 Account 3
Section 2.02 Administrator 3
Section 2.03 Affiliate 3
Section 2.04 Affordable Care Act 4
Section 2.05 Benefit Program 4
Section 2.06 Cafeteria Program 4
Section 2.07 Change in Status 4
Section 2.08 Claimant 5
Section 2.09 Claims Administrator (or "Claims Fiduciary") 5
Section 2.10 COBRA 5
Section 2.11 Code 5
Section 2.12 Company 5
Section 2.13 Compensation 5
Section 2.14 Concurrent Care Claim 5
Section 2.15 Consolidated Appropriations Act 5
Section 2.16 Covered Person 6
Section 2.17 Dependent 6
Section 2.18 Dependent Care Expenses 6
Section 2.19 Domestic Partner 6
Section 2.20 Effective Date 7
Section 2.21 Election Form 7
Section 2.22 Electronic Protected Health Information or EPHI 7
Section 2.23 Employee 7
Section 2.24 Employer 8
Section 2.25 ERISA 8
Section 2.26 FMLA 8
Section 2.27 Genetic Information 8
Section 2.28 Grace Period 8
Section 2.29 Health Care Claim 8
Section 2.30 Health Care Component(s) 8
Section 2.31 Health Care Operations 8
Section 2.32 High Deductible Health Plan 9
Section 2.33 Highly Compensated Participant 9

Table of Contents
(continued)

Page

Section 2.34 HIPAA 9
Section 2.35 HIPAA Health Plan 9
Section 2.36 HIPAA Program 9
Section 2.37 HSA 9
Section 2.38 HSA Benefits 9
Section 2.39 HSA-Eligible Individual 10
Section 2.40 Insurance Company 10
Section 2.41 IRS 10
Section 2.42 Leave of Absence 10
Section 2.43 Medicaid 10
Section 2.44 Medicare 10
Section 2.45 Medical Care Expenses 10
Section 2.46 MHPAEA 10
Section 2.47 Participant 11
Section 2.48 PHS Act 11
Section 2.49 Plan 11
Section 2.50 Plan Year 11
Section 2.51 Post-Service Claim 11
Section 2.52 Pre-Existing Condition 11
Section 2.53 Pre-Service Claim 11
Section 2.54 Privacy Official 11
Section 2.55 Privacy Policy 11
Section 2.56 Privacy Rule 11
Section 2.57 Program Document 11
Section 2.58 Protected Health Information or PHI 11
Section 2.59 QMCSO or Qualified Medical Child Support Order 12
Section 2.60 Relevant 12
Section 2.61 Rescission or Rescinded 12
Section 2.67 Responsible Employee 12
Section 2.68 Section 152 Dependent 12
Section 2.69 Security Incident 12
Section 2.70 Security Official 13
Section 2.71 Security Rule 13
Section 2.72 Spouse 13
Section 2.73 State Child Health Plan 13
Section 2.74 Third Party 13
Section 2.75 TRICARE 13
Section 2.76 Uniformed Service 13
Section 2.77 Urgent Care Claim 14
Section 2.78 USERRA 14

ARTICLE III ELIGIBILITY AND PARTICIPATION 15
Section 3.01 Eligibility to Participate 15

Table of Contents
(continued)

Page

Section 3.02 Participation Conditions 15
Section 3.03 Termination of Participation 16
Section 3.04 Termination of Employment 17
Section 3.05 Continuation of Participation During Leave of Absence 17
Section 3.06 Reinstatement of Former Participant. 20

ARTICLE IV BENEFIT CHOICES AND CONTRIBUTIONS 21
Section 4.01 Participant Contributions Required for Plan Coverage 21
Section 4.02 Benefit Program Choices 21

ARTICLE V ENROLLMENT AND ELECTIONS 22
Section 5.01 Initial Enrollment 22
Section 5.02 Annual Enrollment 22
Section 5.03 Election Forms 23
Section 5.04 Failure to Return Election Form. 23
Section 5.05 Special Enrollment Rules 24
Section 5.06 Modifying and Revoking Elections 26
Section 5.07 Nondiscrimination Requirements. 32

ARTICLE VI FUNDING AND ACCOUNTS 34
Section 6.01 Funding, Trust Agreements, and Insurance. 34
Section 6.02 Benefits Supported Only by Benefit Program 35
Section 6.03 Rights of Participants 35

ARTICLE VII HEALTH CARE SPENDING ACCOUNT 36
Section 7.01 Type of Benefit 36
Section 7.02 Maximum Contribution 36
Section 7.03 Benefits After Termination and Reinstatement After Return. 36
Section 7.04 Medical Care Expenses 37
Section 7.05 Claim and Payment Procedures 37
Section 7.06 Electronic Card Reimbursement 38
Section 7.07 Use It or Lose It Rule; Carryover Feature; Forfeitures. 39

ARTICLE VIII DEPENDENT CARE SPENDING ACCOUNT 41
Section 8.01 Type of Benefit 41
Section 8.02 Maximum Contribution 41
Section 8.03 Benefits During a Leave of Absence or After Termination. 41
Section 8.04 Dependent Care Expenses 42
Section 8.05 Earned Income Limit 43
Section 8.06 Claim and Payment Procedures 43
Section 8.07 Use It or Lose It Rule; Forfeitures. 44
Section 8.08 Statements 44

Table of Contents
(continued)

Page

ARTICLE IX HEALTH SAVINGS ACCOUNT 45
Section 9.01 HSA Benefits 45
Section 9.02 Contributions for Cost of Coverage for HSA; Maximum Limits 45
Section 9.03 Recording Contributions for HSA 45
Section 9.04 Tax Treatment of HSA Contributions and Distributions 46
Section 9.05 Trust/Custodial Agreement; HSA Not Intended to Be an ERISA Plan 46

ARTICLE X 47

HEALTH REIMBURSEMENT ACCOUNT 47
Section 10.01 Type of Benefit 47
Section 10.02 Maximum Contribution 47
Section 10.03 Benefits After Termination 47
Section 10.04 Claim and Payment Procedures 47

ARTICLE XI SPECIAL COVERAGE PROVISIONS 48
Section 11.01 COBRA Continuation Coverage 48
Section 11.02 Conversion of Coverage 55
Section 11.03 Pre-existing Condition Limitation 55
Section 11.04 Required Coverage 55

ARTICLE XII COORDINATION OF BENEFITS AND RECOVERY OF BENEFIT OVERPAYMENT 57
Section 12.01 Coordination of Benefits 57
Section 12.02 Medicare-Eligible Employees and Dependents 59
Section 12.03 Subrogation, Reimbursement and Recovery for Third Party Liability 60
Section 12.04 Recovery of Benefit Overpayment 63
Section 12.05 Termination of Coverage for False Representations or Fraud 63

ARTICLE XIII ADMINISTRATION 64
Section 13.01 Administration 64
Section 13.02 Liability and Indemnification 64
Section 13.03 Powers and Authority of Administrator 64
Section 13.04 Records and Reports 65

ARTICLE XIV CLAIMS ADMINISTRATION 66
Section 14.01 General 66
Section 14.02 Processing of Claims 67
Section 14.03 Health Care Claims. 67
Section 14.04 Disability Claims. 73
Section 14.05 All Other Claims 76
Section 14.06 Exhaustion of Administrative Remedies 78
Section 14.07 Forum Selection 78

Table of Contents
(continued)

Page

Section 14.08 Incompetency 78

ARTICLE XV AMENDMENT AND TERMINATION 79
Section 15.01 Amendment 79
Section 15.02 Termination of the Plan 79

ARTICLE XVI PARTICIPATING EMPLOYERS 80
Section 16.01 Adoption of Plan 80
Section 16.02 Administration 80
Section 16.03 Company as Agent for Employers 80
Section 16.04 Termination 80

ARTICLE XVII HIPAA PRIVACY AND SECURITY 81
Section 17.01 General. 81
Section 17.02 Responsible Employees. 81
Section 17.03 Permitted Uses and Disclosures. 82
Section 17.04 Certification Requirement. 83
Section 17.05 Mitigation. 85

ARTICLE XVIII MISCELLANEOUS PROVISIONS 86
Section 18.01 Limitation of Rights 86
Section 18.02 Rights to Employer Assets 86
Section 18.03 No Assignments 86
Section 18.04 Severability 86
Section 18.05 No Guarantee of Tax Consequences 86
Section 18.06 Unclaimed Benefits 87
Section 18.07 Gender and Number 87
Section 18.08 Governing Law and Forum Selection 87
Section 18.09 Statutory and Regulatory References 87
Section 18.10 Headings 87

APPENDIX A 89

APPENDIX B 90

RIVIAN AND VW GROUP TECHNOLOGY, LLC WELFARE BENEFIT PLAN

ARTICLE I
ESTABLISHMENT AND PURPOSE

Section 1.01 Establishment. Rivian and VW Group Technology, LLC (the "Company") has established and maintains the Rivian and VW Group Technology, LLC Welfare Benefit Plan (the "Plan") for eligible Employees of an Employer effective January 1, 2025.

Section 1.02 Purpose. The purpose of the Plan is: (i) to offer eligible Employees, and for the purposes of COBRA former Employees, an opportunity to obtain certain welfare benefits, as specified in Appendix A; (ii) to provide eligible Employees an opportunity to pay for certain benefits on a pre-tax basis;(iii) to provide eligible Employees an opportunity to fund certain unreimbursed medical care expenses and certain qualifying dependent care expenses; and (iv) to provide eligible Employees an opportunity to contribute to a Health Savings Account on a pre-tax basis. Benefits are provided under the Plan through a number of Benefit Programs.

The Plan is to be administered and interpreted in a manner consistent with the Employee Retirement Income Security Act of 1974 ("ERISA"), applicable provisions of the Internal Revenue Code of 1986 (the "Code"), including the requirements of Sections 79, 105(h), 125, 129, 137, 223 and 9815 of the Code, and the Public Health Service Act (the "PHS Act"). Nothing in this Plan document, however, will subject any Benefit Program to ERISA if the Benefit Program would not otherwise be covered by ERISA. The Benefit Programs not subject to ERISA are identified in Appendix A.

Section 1.03 Benefit Programs. The Plan consolidates a broad range of welfare plan benefits (as defined in Section 3(1) of ERISA) and a "cafeteria plan" within the meaning of Section 125 of the Code ("Cafeteria Program"). The Cafeteria Program includes, among other benefits, a "dependent care assistance program" (as defined in Section 129 of the Code), a health flexible spending arrangement (within the meaning of Section 125 of the Code), contributions to a "health savings account" (as defined in Section 223 of the Code), and a "self-insured medical reimbursement plan" (as defined in Section 105 of the Code).

Benefits are provided to Participants and their respective beneficiaries through one or more Benefit Programs sponsored or maintained by one or more of the Employers. Such Benefit Programs may be funded or unfunded, insured or uninsured, or a combination thereof, and may provide varying benefits to different groups of current and former Employees of the Employers and their respective covered Dependents. The separate Benefit Programs that are consolidated into the Plan are listed in Appendix A. Separate Program Documents which describe the specific benefits provided by each Benefit Program, the individuals covered by each Benefit Program, and the other terms and conditions of each Benefit Program, as amended from time to time, are incorporated herein by reference. The Plan supersedes and replaces any document defining the terms of or describing a Benefit Program that is not incorporated and made part of the Plan. Except as provided in Section 14.01, if the Benefit Program is insured and there is a conflict between the specific terms of a Program Document issued by an Insurance Company and the terms of the Plan, the Program Document will control; however, for purposes of Section 14.01, this Plan document will control, as required by ERISA. For all other Benefit Programs, if there is a conflict between

the specific terms of a Program Document and the terms of the Plan, the Plan will control (unless contrary to applicable law), except that any terms exclusively applicable to a Benefit Program will be set forth in the applicable Program Document.

Section 1.04 Annual Reporting Requirements. All Benefit Programs offered under the Plan will constitute a single plan for purposes of the annual reporting requirements of the Code and ERISA. For purposes of these annual reporting requirements, the Plan will be treated as the surviving plan of a merger of the various health and welfare plans into and with the Company welfare plan. Notwithstanding the foregoing, any separate Benefit Program required to receive an opinion from an independent qualified public accountant pursuant to Section 103(a)(3) of ERISA will be deemed a separate employee benefit plan for purposes of the annual reporting requirement of the Code and ERISA.

Section 1.05 Applicability of Plan. The Plan as amended and restated will apply only to eligible individuals who are Participants on or after January 1, 2025.

Section 1.06 Compliance with Applicable Law.

(a) Compliance with the Affordable Care Act. Notwithstanding anything in the Plan to the contrary, the Plan will comply with the applicable requirements of the Affordable Care Act, as such requirements become effective from time to time with respect to the Plan, and the Plan is to be administered and interpreted in a manner consistent therewith.

(b) Compliance with the Consolidated Appropriations Act. Notwithstanding anything in the Plan to the contrary, the Plan will comply with the applicable requirements of the Consolidated Appropriations Act, as such requirements become effective from time to time with respect to the Plan, and the Plan is to be administered and interpreted in a manner consistent therewith.

(c) Compliance with All Other Applicable Laws. Notwithstanding anything in the Plan to the contrary, the Plan will comply with the requirements of all other applicable laws, as such requirements become effective from time to time with respect to the Plan, and the Plan is to be administered and interpreted in a manner consistent therewith. In no event shall the Plan be treated as failing to be operated in accordance with the terms of the Plan solely as the result of compliance therewith.

ARTICLE II
DEFINITIONS

Whenever used in the Plan, the following words and phrases will have the respective meanings specified in this Article unless the context plainly requires a different meaning, and when the defined meaning is intended the term will be capitalized in the Plan.

Section 2.01 Account means a bookkeeping record maintained by the Plan under Articles VII and VIII with respect to each Participant that reflects, from time to time, the amounts attributable to Compensation reduction contributions made on the Participant's behalf, subject to any distributions or forfeitures incurred. The Accounts will not be funded and will not earn or accrue any interest for the benefit of any Participant.

(a) **Dependent Care Spending Account** means the Account established for a Participant to record the contributions that the Participant has elected to make to such Account and the reimbursements made to such Participant for eligible Dependent Care Expenses.

(b) **Health Care Spending Account** means the Account established and maintained for a Participant to record the contributions that the Participant has elected to make to such Account and the reimbursements made to such Participant for eligible Medical Care Expenses.

(c) **Limited Health Care Spending Account** means a Health Care Spending Account established and maintained for a Participant to record the contributions that the Participant has elected to make to such Account and the reimbursements made to such Participant for eligible Medical Care Expenses; provided however, that the Limited Health Care Spending Account only provides reimbursement for dental and vision expenses. The Limited Health Care Spending Account is maintained within the contemplation of Proposed Treasury Regulations at 26 C.F.R. § 1.125-5(m)(3), so as not to disqualify a Participant from also contributing to an HSA.

(d) **Health Reimbursement Account** means the Account established and maintained for a Participant to record the allocations an Employer makes to such Account and the reimbursements made to such Participant for eligible Medical Care Expenses, in accordance with terms of the applicable Program Document.

Section 2.02 Administrator means the Company, other entity or individual designated from time to time by the Board of Directors of the Company to supervise the administration of the Plan in accordance with Article XIII. The Administrator will be the "named fiduciary" of the Plan, within the meaning of Section 402(a) of ERISA.

Section 2.03 Affiliate means any corporation or other business entity that is: (i) a member of a controlled group of corporations (within the meaning of Section 414(b) of the Code) of which the Company is also a member; (ii) a trade or business under common control with the Company, within the meaning of Section 414(c) of the Code; (iii) a member of an affiliated service group (within the meaning of Section 414(m) of the Code) of which the Company is also a member; or (iv) required to be aggregated with the Company pursuant to regulations issued under Section 414(o) of the Code.

Section 2.04 Affordable Care Act means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, as such amends the applicable provisions of the Code, ERISA, and the PHS Act. For the avoidance of doubt, references in the Plan to the Affordable Care Act include the Transparency in Coverage regulations set forth in 26 C.F.R. §§ 54.9815-2715A1–A3; 29 C.F.R. §§ 2590.715-2715A1–A3; and 45 C.F.R. §§ 147.210–212 (as applicable).

Section 2.05 Benefit Program means a separate welfare plan program that is sponsored by an Employer and that forms part of the Plan. A Benefit Program will also include the Cafeteria Program, the terms and conditions of which are specified herein. A Benefit Program may be governed in whole or in part by a collective bargaining agreement to the extent such agreement provides for welfare benefits covered by the Benefit Program. The Administrator will maintain records as to the particular Benefit Programs from time to time forming part of the Plan and which are listed on Appendix A or identified in a summary plan description.

Section 2.06 Cafeteria Program means the Benefits Program set forth herein that permits eligible Employees to choose between certain benefits provided by the Employer, including contributions to an HSA, or additional cash compensation, as described in Article IV. The Cafeteria Program is intended to qualify as a "cafeteria plan" under Section 125 of the Code and only qualified benefits as defined in Section 125(f) of the Code will be offered under the Cafeteria Program.

Section 2.07 Change in Status means one of the following events, as well as any other event included under subsequent changes to regulations and other guidance issued under Section 125 of the Code that the Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis:

(a) an event that changes the Employee's legal marital status, including marriage, death of the Employee's Spouse, divorce, legal separation or annulment;

(b) a change in the number of the Employee's Section 152 Dependents, including the birth, adoption, placement for adoption (as defined under HIPAA), or death of a Section 152 Dependent;

(c) any change in employment status of the Participant or the Participant's Section 152 Dependent that affects benefit eligibility under a Benefit Program, including: the termination or commencement of employment; strike or lockout; the commencement of or return from an unpaid leave of absence; a change in residence or worksite that would affect the Employee's eligibility for coverage; or a change in employment status that causes the individual to become or cease to be eligible under a Benefit Program (e.g., switching from part-time to full-time status or vice versa, or a similar change if such change causes the individual to lose eligibility for coverage);

(d) a change in employment or marital status that causes the Employee to become eligible for coverage under their Spouse's or Section 152 Dependent's plan if the Employee actually obtains coverage thereunder;

(e) an event that causes a Section 152 Dependent to satisfy or cease to satisfy the eligibility requirements for a particular Benefit Program including, but not limited to, attaining a specified age, getting married, or ceasing to be a student;

(f) a change in employment status of a Spouse or Section 152 Dependent that results in a loss of coverage under the Spouse's or Section 152 Dependent's plan; or

(g) any other event recognized for purposes of changing Plan elections under applicable law and regulations.

See Section 5.06 for requirements that must be met for a Participant to change their election during the Plan Year on account of Change in Status.

Section 2.08 Claimant means any person who believes they are entitled to receive a benefit under the Plan and files a claim in accordance with Article XIV.

Section 2.09 Claims Administrator (or "Claims Fiduciary") means an Insurance Company or other party that has contracted with an Employer to provide claim administration services to a Benefit Program or is responsible for determining whether a particular claim is covered by such Benefit Program. If no other individual or entity is designated as Claims Administrator for a Benefit Program, the Administrator will be the Claims Administrator.

Section 2.10 COBRA means the coverage rights conferred by Section 4980B of the Code and Section 601, *et seq.*, of ERISA (as such statutes were created by Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985).

Section 2.11 Code means the Internal Revenue Code of 1986.

Section 2.12 Company means Rivian and VW Group Technology, LLC and any successor or assign thereof that adopts the Plan by action of its governing body or that contractually assumes the obligations of the Company under the Plan.

Section 2.13 Compensation means the total remuneration paid to the Participant by an Employer for services rendered as an Employee of such entity with respect to the period during which the Employee is a Participant of this Plan for any Plan Year as reported in Box 1 of Form W-2.

Section 2.14 Concurrent Care Claim means, with respect to an ongoing course of treatment to be provided over a period of time or number of treatments, a Health Care Claim to extend such ongoing course of treatment beyond the period of time or number of treatments authorized by the Administrator or Claims Administrator.

Section 2.15 Consolidated Appropriations Act means the Consolidated Appropriations Act, 2021, as such amends the applicable provisions of the Code, ERISA, and the PHS Act. The Consolidated Appropriations Act includes, without limitation, the No Surprises Act (at Division BB—Private Health Insurance and Public Health Provisions, Title I) and Transparency provisions (at Division BB, Title II).

Section 2.16 Covered Person means any Participant or Dependent who is covered under Benefit Program and who is eligible to receive benefits in accordance with the terms of the applicable Benefit Program.

Section 2.17 Dependent means the Participant's Spouse and any other individual who meets the definition of a dependent set forth in the Program Document for a particular Benefit Program. Dependent may include:

(a) the Participant's Spouse;

(b) the Participant's Domestic Partner;

(c) a natural child, stepchild, foster child or legally adopted child (or child placed for adoption) of the Participant, the Participant's Spouse or the Participant's Domestic Partner, until the child turns age 26;

(d) for purposes of the Health Care Spending Account and any other Benefit Program providing medical care, Dependent may include any other individual not described in (a) or (b) above who:

(i) is a dependent as defined in Section 152 of the Code (determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof); or

(ii) is determined to be an alternate recipient of a Participant under a qualified medical child support order (QMCSO).

Section 2.18 Dependent Care Expenses means expenses described in Section 8.04.

Section 2.19 Domestic Partner means an individual who has a committed relationship with the Participant, provided that the Participant and the Domestic Partner certify that they are:

(a) each other's sole domestic partner and intend to remain so indefinitely;

(b) living in the same residence;

(c) both at least age 18 and mentally competent to consent;

(d) not married to each other or to someone else;

(e) not the domestic partner of someone else;

(f) not related by blood to a degree of closeness which would prohibit legal marriage under state law; and

(g) jointly responsible for each other's common welfare and share financial obligations.

Notwithstanding the foregoing, to the extent the above criteria are satisfied, or where required by law, "Domestic Partner" may include a civil union partner or common law spouse

under state law. Participants seeking to enroll a Domestic Partner may be required to complete an affidavit and/or provide substantiating evidence of Domestic Partnership.

Section 2.20 Effective Date means January 1, 2025, which is the date on which the Plan became effective.

Section 2.21 Election Form means such form as the Administrator may approve from time to time for the purpose of enrolling in the Plan or changing or revoking an election. An Election Form may be in written, electronic, voice response or any other form or medium.

Section 2.22 Electronic Protected Health Information or EPHI means PHI that is stored, maintained or transmitted in electronic media.

Section 2.23 Employee means an individual who is treated as a regular employee of an Employer (a) who is paid a salary, wages or other compensation by an Employer; (b) who is considered by an Employer to be an employee at the time of the payment of such salary, wages, or other compensation; and (c) whose salary, wages or other compensation is treated by an Employer at the time of such payment as being subject to statutorily required payroll tax withholding, such as withholding of federal or state income or withholding of the employee's share of social security tax.

All other individuals will not be included within the definition of "Employee", even if one or more of such other individuals is determined by a court, the IRS or any other entity under any federal or state law, rule or regulation to be (or have been) a common law or statutory employee of an Employer for some or all of the period of time in question. Without limiting who is excluded, the following individuals are expressly excluded from the definition of the term "Employee":

(a) any nonresident alien employee who does not have U.S.-source income from the Employer;

(b) any individual who is performing services for an Employer under an independent contractor or consultant agreement or arrangement with an Employer (even if a court, the IRS, or any other entity determines that such individual is a common law employee);

(c) any individual who must be treated as an employee of an Employer for limited purposes under the leased employee provisions of Section 414(n) of the Code;

(d) any individual covered by a collective bargaining agreement that does not provide for coverage under the Plan, provided that the type of benefits provided under the Plan was the subject of good faith bargaining between the individual's bargaining representative and an Employer;

(e) any individual classified by an Employer as a temporary or seasonal employee, unless such individual is required to be offered coverage under the Affordable Care Act's Employer Shared Responsibility requirement, in which case the Plan can choose to extend coverage to such individual;

(f) any individual providing services to an Employer pursuant to an agreement between the Employer and a third party (even if a court, the IRS, or any other entity determines that such individual is a common law employee); or

(g) a person who performs services for an Employer but who is treated for payroll purposes as other than an Employee of the Employer (even if a court, the IRS, or any other entity determines that such individual is a common law employee).

Section 2.24 Employer means the Company and any Affiliate that participates in the Plan pursuant to the procedures outlined in Article XVI.

Section 2.25 ERISA means the Employee Retirement Income Security Act of 1974.

Section 2.26 FMLA means the Family and Medical Leave Act of 1993.

Section 2.27 Genetic Information has the meaning given in Section 2791 of the PHS Act, as amended by the Genetic Information Nondiscrimination Act of 2008.

Section 2.28 Grace Period means the period from the end of a Plan Year up to and including the fifteenth day of the third calendar month after the end of that Plan Year. In order for the Grace Period to apply with respect to an applicable Account, the Participant must be participating in the Account on the last day of that Plan Year to which the Grace Period applies.

Section 2.29 Health Care Claim means a request by a Claimant for a benefit under a Benefit Program that is a group health plan (i.e., an employee welfare benefit plan within the meaning of Section 3(1) of ERISA to the extent that such plan provides "medical care" within the meaning of Section 733(a) of ERISA) that is made in accordance with the rules and procedures established by the Administrator or Claims Administrator.

Section 2.30 Health Care Component(s) means the Benefit Programs of the Plan that constitute HIPAA Health Plans, including the Health Care Spending Account.

Section 2.31 Health Care Operations as defined under 45 C.F.R. § 164.501, means any of the following activities to the extent that they are related to a HIPAA Health Plan's covered functions:

(a) Conducting quality assessment and improvement activities; population-based activities related to health improvement, reduction of health care costs, case management and care coordination; contacting health care providers and patients regarding treatment alternatives; and related functions that do not include treatment;

(b) Reviewing competence or qualifications of health care professionals and evaluating provider and HIPAA Health Plan performance;

(c) Underwriting and other activities that relate to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance);

(d) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(e) Business planning and development, such as cost-management and planning-related analysis related to managing and operating the HIPAA Health Plan, and development or improvement of coverage policies; and

(f) Business management and general administrative activities, including, but not limited to: (A) management activities related to implementation of and compliance with the requirements of the Privacy Rules; (B) customer service, including the provision of data analyses for the HIPAA Health Plan sponsor, provided that PHI is not disclosed to the HIPAA Health Plan sponsor; (C) resolution of internal grievances; (D) due diligence related to the sale, transfer, merger, or consolidation of all or part of a HIPAA Health Plan with another entity directly regulated under the Privacy Rule, or an entity that, following such activity, will be subject to the Privacy Rule; and (E) consistent with applicable requirements of the Privacy Rule, creating de-identified information, as defined in 45 C.F.R. § 164.514(b)(2), or a limited data set, as defined under 45 C.F.R. § 164.514(d)(2).

Section 2.32 High Deductible Health Plan means the high deductible health plan offered by the Company that is intended to qualify as a "high deductible health plan" under Section 223(c)(2) of the Code, as described in materials provided separately by the Company.

Section 2.33 Highly Compensated Participant means a Participant who is a "highly compensated participant," as defined in Section 125(e) of the Code.

Section 2.34 HIPAA means the Health Insurance Portability and Accountability Act of 1996, as codified in Section 9801, *et seq*., of the Code, and Section 701, *et seq*., of ERISA. Notwithstanding the foregoing, for the purpose of Article XVII, "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as codified in 42 U.S.C. §§ 1320d, *et seq*. (including by the Health Information Technology for Economic and Clinical Health Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009).

Section 2.35 HIPAA Health Plan as defined under 45 C.F.R. § 160.103, means a health plan subject to the Privacy Rule that provides, or pays the cost of, medical care, and includes those plans and arrangements listed in 45 C.F.R. § 160.103.

Section 2.36 HIPAA Program means a Benefit Program subject to the portability (including special enrollment) and nondiscrimination requirements of HIPAA, including as required by Section 9801(f) of the Code.

Section 2.37 HSA means a "health savings account" established under Section 223 of the Code. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by a Participant with a qualified trustee or custodian.

Section 2.38 HSA Benefits has the meaning described in Section 9.01.

Section 2.39 HSA-Eligible Individual means an individual who is eligible to contribute to an HSA under Section 223 of the Code and who has elected qualifying High Deductible Health Plan coverage offered by the Company and who has not elected any disqualifying non-High Deductible Health Plan coverage offered by the Company.

Section 2.40 Insurance Company means an insurance company through which Benefit Program benefits are insured or which provides administrative services to a Benefit Program. For purposes of this definition, a health maintenance organization, exclusive provider organization or preferred provider organization may constitute an Insurance Company. Any insurance contract or certificate and any contract with such an organization maintained in connection with a Benefit Program will form part of the Plan and is incorporated herein by this reference.

Section 2.41 IRS means the Internal Revenue Service, a bureau of the U.S. Department of the Treasury (the "Treasury"). (Any reference in the Plan to regulations or other guidance issued by the IRS shall also include applicable guidance issued by the Treasury.)

Section 2.42 Leave of Absence means a period of employer-approved absence from service that is not treated as a termination of employment in accordance with the Employer's employment policies.

Section 2.43 Medicaid means Title XIX of the Social Security Act.

Section 2.44 Medicare means Part A, B or D of Title XVIII of the Social Security Act.

Section 2.45 Medical Care Expenses mean the expenses incurred by the Participant or their "eligible dependent(s)" for "medical care" as defined in Section 213(d) (disregarding Sections 213(d)(1)(C) and (D)) of the Code and as supplemented from time to time with respect to the applicable Account pursuant Sections 105,106, and 125 of the Code (including, without limitation, in Section 106(f) of the Code and in Proposed Treasury Regulations at 29 C.F.R. § 1.125-5(k)); provided, however, that any such expense is reimbursable only to the extent that the Participant or eligible dependent incurring the expense has not been reimbursed and, to the extent required by the Code, the individual certifies that they will not seek reimbursement, for the expense through insurance or otherwise (other than under the Account). If only a portion of a Medical Care Expense has been reimbursed elsewhere, then the Account can reimburse the remaining portion of such Medical Care Expense. For the purpose of this definition, "eligible dependent(s)" include a Participant's Spouse and Section 152 Dependent, including any child (as defined in Section 152(f)(1) of the Code) of the Participant who as of the end of the taxable year, has not attained age 27. The Administrator or the Claims Administrator may establish procedures regarding the eligibility of various expenses for (and conditions for) reimbursement as Medical Care Expenses and may limit reimbursement of expenses as described in such procedures. For purposes of a Limited Health Care Spending Account, Medical Care Expenses will only include dental and vision expenses.

Section 2.46 MHPAEA means the Mental Health Parity Act of 1996, as amended by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, codified at Section 712 of ERISA and Section 9812 of the Code.

Section 2.47 Participant means (a) a current Employee who participates in a Benefit Program, or (b) a former Employee who is covered by a Benefit Program or is eligible to receive a benefit under a Benefit Program.

Section 2.48 PHS Act means the Public Health Service Act.

Section 2.49 Plan means the Rivian and VW Group Technology, LLC Welfare Benefit Plan, as set forth herein, together with any and all amendments, supplements and appendices hereto.

Section 2.50 Plan Year means the year, consisting of the twelve consecutive month period commencing on January 1 and ending on the next following December 31.

Section 2.51 Post-Service Claim means a Health Care Claim that is not a Pre-Service Claim, Urgent Care Claim or Concurrent Care Claim. For purposes of Section 7.05, all requests for reimbursement from a Participant's Health Care Spending Account, and for purposes of Section 10.04, all requests for reimbursement from a Health Reimbursement Account, will constitute Post-Service Claims.

Section 2.52 Pre-Existing Condition is any condition (physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended by a physician or received from a physician in the period provided by a Program Document.

Section 2.53 Pre-Service Claim means a Health Care Claim with respect to which the terms of a Benefit Program condition receipt of the benefit, in whole or in part, on approval of the benefit in advance by the Administrator or Claims Administrator in advance of obtaining medical care.

Section 2.54 Privacy Official means the individual named under the Plan's Privacy Policy or other appropriate individual as designated by the Company.

Section 2.55 Privacy Policy means the Plan's Privacy Policy, as presently stated and as may be restated or amended from time to time.

Section 2.56 Privacy Rule means the regulations issued under HIPAA concerning the privacy of health information.

Section 2.57 Program Document means the written description of the terms of each separate Benefit Program, including but not limited to a summary plan description, summary of material modifications, schedule of benefits, benefits booklet, or Insurance Company contract or certificate.

Section 2.58 Protected Health Information or PHI means individually identifiable health information that (i) relates to the past, present, or future physical or mental condition of a current or former Participant, provision of health care to a Participant, or payment for such health care; (ii) can either identify the Participant, or there is a reasonable basis to believe the information can be used to identify the Participant; and (iii) is received or created by or on behalf of a HIPAA

Health Plan. For purposes of defining PHI, Genetic Information will be treated as health information.

Section 2.59 QMCSO or Qualified Medical Child Support Order means a "medical child support order" within the meaning of Section 609(a)(2) of ERISA that satisfies the requirements of the QMCSO procedures established by the Administrator in accordance with Section 609(a) of ERISA. An appropriately completed National Medical Support Notice shall be deemed to constitute a QMCSO, as required by Section 609(a)(5)(C) of ERISA.

Section 2.60 Relevant means a document, record, or other information that is "relevant" to a claim for benefits within the meaning of 29 C.F.R. § 2560.503-1(m)(8).

Section 2.61 Rescission or Rescinded means a "rescission" within the meaning of the Affordable Care Act (as set forth in 29 C.F.R. § 2590.715-2712(a)(2)). In general, a Rescission (or coverage that has been Rescinded) is the cancellation or discontinuance of a Benefit Program providing medical coverage that has a retroactive effect, but does not include, for example, a retroactive cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions (e.g., for COBRA coverage) or that is initiated by the Participant without influence by the Company, an Employer, the Plan, etc. The term "Rescission" also includes a cancellation or discontinuance of a Benefit Program providing disability coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of disability coverage (29 C.F.R. § 2560.503-1(m)(4)(ii)).

Section 2.67 Responsible Employee means an employee (including a contract, temporary, or leased employee) of the HIPAA Health Plans or of the Company or an Affiliate whose duties (i) require that the employee have access to PHI for purposes of HIPAA Health Plan Payment or Health Care Operations; or (ii) make it likely that they will receive or have access to PHI. Persons designated as Responsible Employees are described in Section 17.02. A Responsible Employee will also include any other employee (other than a designated Responsible Employee) who creates or receives PHI on behalf of a HIPAA Health Plan, even though their duties do not (or are not expected to) include creating or receiving PHI. Responsible Employees are within the Company's HIPAA firewall when they perform HIPAA Health Plan functions.

Section 2.68 Section 152 Dependent means a Dependent who is defined as a dependent in Section 152 of the Code (determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof for purposes of the Health Care Spending Account and any Benefit Program providing medical care). For purposes of Health Care Spending Accounts and any Benefit Program providing medical care, a child of a divorced Participant who would be a dependent (as defined in Section 152 of the Code) but for the fact that the divorce decree permits the Participant's former spouse to claim the child as a dependent for tax purposes will be considered a Section 152 Dependent of the Participant for purposes of the Plan.

Section 2.69 Security Incident means, as defined under 45 C.F.R. § 164.304 the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Section 2.70 Security Official means the individual named in the Company's security policies, or other appropriate individual as designated by the Company.

Section 2.71 Security Rule means the regulations issued under HIPAA concerning the security of Electronic Protected Health Information.

Section 2.72 Spouse means a Participant's husband or wife who:

(a) has met all the requirements of a valid marriage contract in a jurisdiction which recognizes the marriage;

(b) meets the requirements of a spouse under federal tax law; and

(c) is covered by a Benefit Program.

Spouse does not include an individual who is married under common law or who is legally separated from a Participant, unless recognized under the applicable Program Document or required by law. For purposes of the Dependent Care Spending Account, "Spouse" will not include an individual who, although married to the Participant, files a separate federal income tax return, maintains a separate principal residence during the last six months, and does not furnish more than one-half of the cost of maintaining the principal residence of the qualifying individual (as defined in Section 8.04(b)).

Section 2.73 State Child Health Plan has the meaning set forth under the Children's Health Insurance Program under Title XXI of the Social Security Act (or "CHIP").

Section 2.74 Third Party means any person or entity who is or may be liable for an injury, illness, disability, or death of a Covered Person including without limitation, an insurance company for such Third Party or a potentially liable person or entity; worker's compensation; homeowner's insurance; all coverages under an automobile policy of the Covered Person or a member of the Covered Person's family, including "no fault" coverage, medical coverage, and uninsured or underinsured motorist coverage; and other similar coverages. If appropriate under the circumstances, the Covered Person or any insurer of the Covered Person may be considered a Third Party if the Covered Person is or may be responsible for the injury, illness, disability or death of a Covered Person and/or the Covered Person has insurance coverage for such injury, illness, disability or death.

Section 2.75 TRICARE means the managed health care program established by the Department of Defense under Chapter 55 of Title 10, United States Code, for active duty and retired members of the uniformed services, their families, and survivors.

Section 2.76 Uniformed Service means the performance of duty on a voluntary or involuntary basis under competent authority, and includes active duty, inactive duty for training, initial active duty for training, full-time National Guard duty, and a period during which an Employee is absent from employment with an Employer for the purpose of an examination to determine the fitness of the Employee to perform any such duty in the United States Armed Forces, the Army National Guard and the Air National Guard (when engaged in active duty for training, inactive duty training or full-time National Guard duty), the commissioned corps of the Public

Health Service and any other category of person designated by the President of the United States in time of war or emergency.

Section 2.77 Urgent Care Claim means a Health Care Claim for medical care not yet performed but, if delayed:

(a) could seriously jeopardize the Claimant's life, health, or the ability to regain maximum function; or

(b) in the opinion of a physician who has knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or medical treatment for which the Claimant is filing the claim.

Section 2.78 USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994.

ARTICLE III
ELIGIBILITY AND PARTICIPATION

Section 3.01 Eligibility to Participate. Except as specifically provided otherwise in an applicable Program Document, each Benefit Program will cover all full-time Employees who are regularly scheduled to work 30 or more hours per week, part-time Employees regularly scheduled to work 20 or more hours per week, and an otherwise eligible Employee on short-term disability, in accordance with the terms of applicable Program Document; provided, however, that no former Employee or their Dependents will be covered by any Benefit Program unless such Benefit Program expressly covers the individual as a former Employee or as a Dependent of a former Employee, such as in the case of COBRA continuation coverage. Except as specifically provided otherwise in an applicable Program Document, in no event will an Employee be covered as both a Participant and Dependent, or a Dependent be covered as a Dependent of more than one Participant.

Except where otherwise provided in an applicable Benefit Program or as agreed upon in connection with a joint venture or acquisition, an Employee who is eligible to participate in a Benefit Program will become a Participant upon the later of:

(a) For eligible full-time Employees, the first day of the month following the date of hire, or for eligible part-time Employees, the first day of the month coincident with or next following the completion of three (3) consecutive months of service with an Employer, provided that the Employee appropriately and timely completed the Election Form as determined by the Administrator;

(b) for purposes of late entrants under the life insurance Benefit Program, the first day of the next Plan Year or, if evidence of insurability is required, the date set forth in an approval of coverage (as applicable) from the Insurance Company; or

(c) in the event that the Employee did not previously enroll, the date applicable under Section 5.01.

Notwithstanding the foregoing, to the extent specified in writing by the Board of Directors, if a waiting period for a Benefit Program is waived for an Employee or a particular group of Employees with respect to a self-insured group health plan, then the Benefit Program (to the extent such waiting period is waived or different benefits are offered thereunder) will be treated as a "separate plan" within the meaning of the last sentence of 26 C.F.R. § 1.105-11(c)(4)(i).

Section 3.02 Participation Conditions. As a condition of participation and receipt of benefits under this Plan, each Participant will:

(a) timely submit an application to participate under the Plan to the Administrator in accordance with Article V;

(b) designate a portion of their Compensation, if any, as a Contribution to the Plan in accordance with Article IV and consent to have such amount withheld as a salary reduction contribution;

(c) observe all Plan rules and regulations;

(d) consent to the Administrator's inquiries with respect to any physician, hospital, or other medical care provider or other services involved in a determination for eligibility of coverage or a benefits claim under the Benefit Programs, or for reimbursement of Medical Care Expenses or Dependent Care Expenses;

(e) submit to the Administrator all reports, bills, and other information that the Administrator may reasonably require, including but not limited to (i) information about Covered Persons necessary for compliance with the Affordable Care Act and/or secondary payer reporting requirements under Medicare; and (ii) written substantiation by a third party of the amount of any Medical Care Expense or Dependent Care Expense to be reimbursed, and a written statement by the Participant that such expense is not reimbursable through other sources; and

(f) assure that any individual that they enroll as a Dependent satisfies the definition to be considered as a Dependent under the applicable Benefit Program.

Section 3.03 Termination of Participation.

(a) Except as otherwise specifically provided herein or in the applicable Program Document, coverage for a Participant under a Benefit Program will terminate when the earliest of the following events occurs:

(i) The Participant ceases to be an Employee of all Employers;

(ii) The Participant is no longer eligible to participate in the Plan;

(iii) The Participant fails to timely pay any required Participant contributions;

(iv) The Participant elects not to participate in a Benefit Program for the subsequent Plan Year during Annual Enrollment;

(v) The Company terminates the Benefit Program or amends the Benefit Program in a manner that it no longer applies to the Participant or Dependent;

(vi) The date coverage is terminated because the Participant commits fraud upon the Plan;

(vii) The date the Participant goes on strike or is locked out to the extent not prohibited by the applicable collective bargaining agreement; or

(viii) 90 days after the Administrator requests repayment from the Participant (or any Dependent) of amounts that are subject to reimbursement under any Benefit Program, overpayments or mistaken payments from a Benefit Program, unless such Participant (or Dependent) repays such amounts or sets up a repayment schedule for same that is approved by the Administrator in its sole discretion.

(b) Coverage for a Participant's covered Dependent under a Benefit Program will terminate when the first of the following occurs:

(i) The Participant ceases to be covered; or

(ii) The covered Dependent is no longer an eligible Dependent.

Notwithstanding the foregoing, for purposes of the medical Benefit Program, dependent coverage will continue through the end of the year in which the dependent turns 26.

(c) Except where otherwise provided in the applicable Program Document, in the event that coverage terminates upon one of the events identified above in this Section, such termination will be effective at the end of the month in which such event occurs. Notwithstanding the foregoing, for purposes of Section 3.03(a)(iii), if the Participant fails to make such premium payment within 30 days of the date the payment would otherwise be due, coverage shall terminate retroactive to the last date on which premiums were paid. Compensation reductions to pay for the cost of coverage will end effective for the period during which the loss of coverage occurred. Notwithstanding the foregoing, if a Participant and/or their covered Section 152 Dependent are eligible for and elect COBRA in accordance with Section 11.01, participation will terminate at the end of the applicable COBRA continuation coverage period.

Section 3.04 Termination of Employment. Notwithstanding any provision of the Plan to the contrary, a Participant who terminates employment with all Employers may, as applicable, receive benefits after such termination under Section 7.03, Section 8.03 or Article XI. To the extent that a Participant's termination constitutes a Change in Status, the Participant may modify or revoke their prior Plan elections in accordance with Section 5.06(a).

Section 3.05 Continuation of Participation During Leave of Absence. A Participant taking a paid or unpaid Leave of Absence may elect to continue to participate in the Plan using the benefit election that is in effect on the day immediately preceding the first day of such leave; provided, however, that to the extent that the Leave of Absence constitutes a Change in Status, the Participant may modify their Plan election as provided in Section 5.06(a). Notwithstanding the foregoing, a Participant will only be allowed to maintain coverage under the Plan while on a Leave of Absence if the Participant continues to have an employment relationship with an Employer, maintains their eligibility to participate in the applicable Benefit Program, and makes all required Participant contributions. When an Employee is on a continuous leave of absence for 26 weeks or greater, any Employer sponsored medical, dental, and vision benefit programs will be terminated at the end of the month in which the Employee begins their 26th week of leave, unless otherwise prohibited by applicable law. At that time, Employees will receive information on how to continue coverage through COBRA if they so choose to elect. Upon an Employee's return to work, they will then be able to re-enroll in medical, dental, and vision benefits as applicable.

(a) Participating During Unpaid Leave of Absence. A Participant taking an unpaid Leave of Absence who elects to continue their participation during such leave will pay their required contributions under an arrangement agreed upon between the Participant and the Administrator where the Administrator will fund coverage during the unpaid Leave of Absence and withhold pro-rata "catch-up" amounts from the Participant's compensation on a pre-tax basis

upon the Participant's return from such Leave of Absence. Upon the Participant's return, premiums will be collected via payroll deductions in accordance with applicable law.

(b) Participation During a Paid Leave of Absence. A Participant who is on a paid Leave of Absence may continue to participate in the Plan on the same basis as an active Employee, and their required contributions will be collected upon their return to work via payroll deductions as described in the prior paragraph.

(c) USERRA. A Participant who is entitled to the protection of USERRA when taking a Leave of Absence to perform Uniformed Service will have the following additional rights:

(i) Uniformed Service for 30 Days or Less. If a Participant takes a Leave of Absence to perform Uniformed Service for a period of 30 days or less, the Participant will be treated as being actively at work during such Leave under Benefit Programs providing group health plan coverage (within the meaning of USERRA). During such period, the Participant will pay the same amount, if any, that a Participant who does not take such Leave pays for such coverage.

(ii) Uniformed Service for 31 Days or More. If a Participant takes a Leave of Absence to perform Uniformed Service for a period of 31 days or more, the Participant may continue group health plan coverage under the applicable Benefit Programs for themself and each of their Covered Dependents. Such continued coverage will begin on the effective date of the Participant's Leave of Absence to perform Uniformed Service and end on the earliest of the following dates:

(A) the last day of the 24th month after the effective date of the Leave of Absence;

(B) the date the Participant fails to make a required USERRA contribution payment; or

(C) the date the Participant fails to return to or apply for a position of reemployment within the applicable time frame set forth in USERRA.

A Participant who elects continued coverage while on such Leave will be required to pay the total amount of the cost of the coverage provided under the Benefit Program during the period of such Leave for the Participant and their Covered Dependents, as determined by the Administrator, plus 2%.

(iii) Relationship With COBRA. The USERRA continuation rights described above are independent of the Participant's right to elect COBRA continuation coverage. Notwithstanding the foregoing, if the Participant's Leave of Absence to perform Uniformed Service results in a loss of group health plan coverage, the Participant will be entitled to elect COBRA continuation coverage and if elected, COBRA continuation coverage will

begin after the 30 day period described in subparagraph (i) ends. In all other respects, the Participant's COBRA continuation rights will run concurrently with the USERRA continuation rights.

(iv) Other Benefits. A Benefit Program that does not provide group health plan benefits will provide continuation coverage for Participants entitled to protection under USERRA to the same extent such coverage is made available to a Participant under the Employer's Leave of Absence policy that provides the most favorable continuation treatment under that Benefit Program.

(v) Reinstatement of Benefits. A Participant whose benefits have terminated during their Leave of Absence to perform Uniformed Service will be entitled to have such benefits reinstated upon their reemployment, to the extent provided under USERRA.

(d) FMLA. A Participant who takes a Leave of Absence under FMLA will continue to participate in their elected Benefit Programs while on such Leave as provided above under subsection (a) or (b). If premiums are changed while a Participant is on such Leave, the Participant will pay the new premium rates. If the Participant fails to timely pay the required cost of coverage in accordance with Department of Labor regulations issued under the FMLA, the Participant's coverage under the Benefit Programs may be terminated in accordance with such regulations.

(i) Employer's Right to Recoup Contributions. The Employer has the right to recover contributions it pays for maintaining group health plan coverage during a Participant's unpaid Leave of Absence under the FMLA when the Participant fails to return to work after such Leave ends. For purposes of the foregoing, a Participant who returns to work for at least 30 days is considered to have "returned" to work. The Employer will not have any such right, however, if the Participant's failure to return to work is due to:

(A) a serious health condition of the Participant or a family member that would entitle the Participant to a Leave of Absence under the FMLA; or

(B) other circumstances beyond the Participant's control, such as the Participant's Spouse unexpectedly being transferred to a job location more than 75 miles from the Participant's work site, a relative or individual other than an immediate family member having a serious health condition and the Participant being needed to provide care, or the Participant being laid off while on leave. (Circumstances beyond the Participant's control do not include a mother deciding not to return to work to stay home with a newborn child or a Participant remaining in a distant location with a parent who no longer requires the Participant's care.)

(C) If a Participant does not return to work because of the reasons provided in subparagraph (A) or (B) above, the Employer may require medical certification of the Participant's or family member's serious health condition. If the Participant does not provide such certification within 30 days of the Employer's request the Employer may recover from the Participant group health plan contributions paid during the period of an unpaid Leave of Absence under the FMLA.

(ii) Relationship with COBRA. A qualifying event for purposes of COBRA continuation coverage occurs if, after the end of an unpaid Leave of Absence under the FMLA (as determined under Department of Labor regulations), a Participant does not return to work and, but for COBRA continuation coverage, that Participant would lose group health coverage. In such a case, the qualifying event will be deemed to have occurred on the last day of the Participant's Leave of Absence and the Participant may elect COBRA continuation coverage.

Section 3.06 Reinstatement of Former Participant.

(a) Rehires. Except as provided in Article VII, a Participant who terminates employment will be deemed to have revoked their election and terminated their receipt of benefits under this Article with respect to expenses incurred after the date of such employment termination. If a Participant who terminates employment is rehired within 30 days, however, the Participant's prior election will be automatically reinstated. If a Participant is rehired more than 30 days after termination of employment, the rehired Employee may make a new election in accordance with Article V provided they are still eligible. In addition, a rehired Employee may make an election that corresponds with the special enrollment rights set forth in Section 5.05. With respect to the Health Care Spending Account, if a Participant is rehired within 30 days, the Participant will have access to the full amount designated by the Participant to be credited to such Account for that entire Plan Year, and the Participant will not be required to make up any contributions missed during the period of termination of employment.

(b) After FMLA Leave. Upon returning from FMLA leave, if coverage terminated while on FMLA leave (either by revocation or nonpayment of any required Participant contribution), the Employee may choose to prospectively reinstate their election for coverage under any group health plan (as defined in Section 5000(b)(1) of the Code), including the Health Care Spending Account. If the Employee does not elect to reinstate their election for coverage under any group health plan, the Employer may nevertheless require the Employee to resume participation if the Employer also requires Employees returning from unpaid non-FMLA leave to resume participation upon return from leave. See Section 7.03(b) regarding reinstatement of coverage under the Health Care Spending Account after FMLA leave.

ARTICLE IV
BENEFIT CHOICES AND CONTRIBUTIONS

Section 4.01 Participant Contributions Required for Plan Coverage. The Employer will determine whether any of the Benefit Programs will require Participants to contribute toward the cost of coverage. Any Benefit Programs that do require Participant contributions will be designated as optional Benefit Programs. The Employer will establish the cost of coverage applicable to Participants under the optional Benefit Programs, may adjust such costs from time to time, and will determine whether such costs are to be paid by the Participants on a pre-tax (when permitted by applicable law; e.g., Section 125 of the Code) or an after-tax basis. A Participant who is an Employee will be required to contribute such cost of coverage under the optional Benefit Programs elected under the Plan by automatic reduction of the Participant's Compensation on a pre-tax or after-tax basis, as applicable. Compensation reductions to pay for the cost of coverage will begin effective as of the coverage date. The Administrator will track the Participant contributions and apply them toward the cost of coverage of the optional Benefit Program.

Section 4.02 Benefit Program Choices. Benefit Programs that do not require Participant contributions will be automatically available to Employees who are eligible under the terms of the applicable Benefit Program. An eligible Employee may also elect under this Plan to obtain coverage under the optional Benefit Programs for which they are eligible in accordance with the procedures described in Article V. If such Employee so elects, a portion of their Compensation will be applied by the Employer on a pre-tax or after-tax basis (as the case may be) to satisfy the Employee cost of such optional Benefit Programs. While a Participant's election to receive and pay for certain benefits may be made under this Plan, the benefits will be provided pursuant to the applicable underlying Program Documents.

ARTICLE V
ENROLLMENT AND ELECTIONS

Section 5.01 Initial Enrollment. Each Employee who becomes eligible to participate in an optional Benefit Program pursuant to Section 3.01 of the Plan will be furnished with enrollment materials and given the opportunity to elect to participate. A Participant's enrollment will become effective pursuant to the provisions of the applicable Benefit Program, assuming the Participant files a completed Election Form within 14 days of the date the Participant would otherwise be eligible to enroll, except where agreed upon in connection with a joint venture or acquisition.

(a) Mid-Year Enrollment. Any individual who was not eligible to participate as of the first day of a Plan Year but who becomes eligible to participate in the Plan during that Plan Year may elect to participate in the Plan. Such individual must file with the Administrator a completed Election Form within 14 days of becoming eligible to participate in the Plan (after receiving a written description of the available Benefit Programs). If such an individual fails to file a completed Election Form within 14 days, such individual will be treated as waiving their right to participate in the optional Benefit Programs (other than employee-only medical, in accordance with the Administrator's procedures) under the Plan for the remainder of such Plan Year, subject to Section 5.05.

Mid-year enrollment under this Section will become effective pursuant to the provisions of the applicable Benefit Program, assuming the Participant files a completed Election Form within 14 days of the date the Participant would otherwise be eligible to enroll, except where agreed upon in connection with a joint venture or acquisition. Compensation reductions to pay for the cost of coverage elected under this Section will begin for the period coinciding with or next following the effective date of mid-year enrollment.

(b) Initial Enrollment for Subsequent Plan Years. Any Employee who is eligible to participate but who previously waived or revoked participation may commence participation in the Plan as of the start of a subsequent Plan Year by filing with the Administrator, within the designated enrollment period, a completed Election Form by which the Employee elects to participate in one or more of the optional Benefit Programs for such Plan Year pursuant to Section 5.02. Any election made under this Section will be subject to the terms of the underlying Program Document.

Section 5.02 Annual Enrollment. Before the first day of each Plan Year, each Employee who is eligible to participate in the Plan as of the start of the next upcoming Plan Year and each Employee on FMLA leave will be furnished with an Election Form and given the opportunity to elect to participate in the optional Benefit Programs for that next Plan Year. (An Employee's entitlement to a Benefit Program other than a group health benefit while on FMLA leave will be determined by the Employer's policies for providing such benefits while an Employee is on a non-FMLA leave.) A current description of the Benefit Programs for which the Employee would be eligible if they elected to participate will also be furnished to the Participant before or at the start of the election period. To be valid, the Election Form must be completed and returned to the

Administrator on or before the end of the designated election period for the Plan Year to which it applies.

(a) On the Election Form, the Employee will designate the optional Benefit Programs in which they elect to participate for the applicable Plan Year as well as the applicable level of coverage under such Benefit Program and the identity of any Dependents to be covered.

(b) The Election Form will take effect as of the first day of such Plan Year and will remain in effect throughout the Plan Year unless modified or revoked in accordance with Section 5.05 or 5.06. Each Participant's Election Form will be valid for one Plan Year and must be renewed from Plan Year to Plan Year subject to Section 5.04(b).

Section 5.03 Election Forms. Elections and revocations of elections will be made on such Election Forms, and in accordance with such rules, as may be provided or established from time to time by the Administrator. The Administrator will make Election Forms available to Employees or Participants (a) upon request, (b) within a reasonable time following an Employee's date of hire (or initial eligibility) and before an Employee becomes a Participant, and (c) within a reasonable time before the beginning of each Plan Year.

Section 5.04 Failure to Return Election Form.

(a) Initial Election. If an Employee fails to return a completed Election Form to the Administrator on or before the specified due date for the initial Plan Year, that failure will constitute an election not to participate in the optional Benefit Programs (other than employee-only medical, in accordance with the Administrator's procedures) and an election to receive the Employee's full Compensation in cash, except that the Administrator reserves the right to select one or more default enrollment option(s) and deem the Employee to have elected coverage in such default option(s).

(b) Automatic Renewals. A Participant's failure to return a completed Election Form to the Administrator on or before the specified due date for any subsequent Plan Year will constitute (i) a re-election of the same Benefit Program benefits and coverage, if any, as were in effect for the Participant immediately before the end of the preceding Plan Year, except for the Health Care Spending Account, Dependent Care Spending Account, Limited Health Care Spending Account and HSA; (ii) an agreement to reduce the Participant's Compensation for the subsequent Plan Year in an amount equal to the Participant's share of the cost during such Plan Year of the relevant optional Benefit Programs and coverages; and (iii) an election to not participate in the Health Care Spending Account, Dependent Care Spending Account, Limited Health Care Spending Account and HSA for the upcoming Plan Year.. For any subsequent Plan Year in which the Administrator requires affirmative enrollment (if applicable and as communicated in enrollment materials), failure to return an Election Form shall constitute either an election not to participate in the Plan or, if specified in applicable enrolment materials, a default election for particular Benefit Programs under the Plan. Any Participant who does not desire the same Benefit Program benefits and coverage for the next Plan Year or who wishes to enroll in the Health Care Spending Account, Dependent Care Spending Account, Limited Health Care Spending Account or HSA must, on or before the end of the designated election period, file with the Administrator a completed Election Form with respect to the upcoming Plan Year. The

Administrator reserves the right to conduct an affirmative enrollment when it sees fit, in its sole discretion.

Section 5.05 Special Enrollment Rules. Notwithstanding anything contained herein to the contrary, if an Employee does not timely enroll in a HIPAA Program when such program would otherwise permit the Employee to enroll themself (and/or their eligible Dependents) and the Employee subsequently wishes to elect such coverage, the Employee may do so in appropriate circumstances under these special enrollment rules.

(a) Loss of Coverage. An Employee may enroll for health coverage under a HIPAA Program for the Employee and their eligible Dependents if

(i) the Employee (and, if applicable, their eligible Dependents) is eligible for health coverage under that program but is not currently enrolled;

(ii) the Employee declined health coverage under that program when it was offered previously and, if required by the Plan, gave the existence of alternative health coverage as the reason for waiving such coverage on the Employee's health Benefit Program Election Form; and

(iii) the alternative coverage has terminated, because either

(A) it was COBRA continuation coverage that has been exhausted (this does not include COBRA coverage that terminates because of failure to pay contributions or for cause), or

(B) eligibility for the alternative coverage was lost, including but not limited to, as a result of

(1) legal separation,

(2) divorce,

(3) death,

(4) termination of employment,

(5) reduction in the number of hours of employment,

(6) an individual ceasing to reside, live, or work in an HMO service area (whether or not within the choice of the individual), in the case of coverage under an HMO (or other arrangement) that does not provide benefits to individuals who cease to reside, live or work in the service area,

(7) an individual meeting or exceeding a lifetime limit on benefits,

(8) cessation of Section 152 Dependent status,

(9) the plan no longer offering benefits to the class of similarly situated individuals that includes the individual, or

(10) for reasons other than the individual's failure to pay contributions or for cause, as provided in applicable regulations,

(C) employer contributions toward the cost of the coverage terminated, or

(D) notwithstanding anything in the Plan to the contrary, if the alternative coverage was under a Medicaid plan or under a State Child Health Plan, and the Participant or Section 152 Dependent lost eligibility for such coverage, provided that the Participant requests coverage under the Plan not later than 60 days after the date of termination of such alternative coverage.

In this case, the Employee must submit a completed Election Form within 30 days after the date on which (i) COBRA continuation coverage was exhausted, or (ii) the coverage terminated because of loss of eligibility for coverage or the termination of employer contributions toward the cost of the coverage. Enrollment in a HIPAA Program pursuant to this paragraph will be effective as of the date Employee submits a completed Election Form, provided the Administrator receives a completed Election Form within 30 days of the relevant event.

(b) New Dependent. In addition, an Employee may enroll for health coverage under a HIPAA Program for the Employee and their eligible Section 152 Dependents if (i) the Employee is eligible for health coverage under that program but is not currently enrolled, or is currently enrolled but their new Section 152 Dependent is not currently enrolled; and (ii) another individual (a Spouse or child) has become a Section 152 Dependent of the Employee through marriage, birth, adoption, or placement for adoption.

In this case, the Employee must submit a completed Election Form within 30 days of the marriage, birth, adoption, or placement for adoption unless a Benefit Program allows a longer period of time. Enrollment in a HIPAA Program pursuant to this Section will be effective the date of the event, provided the Administrator receives the completed Election Form within 30 days of the event. If the HIPAA Program permits the Employee to elect coverage retroactive to his or her date of marriage, at the Plan Administrator's sole discretion, the Employee will pay his or her share of the cost of such retroactive coverage with after-tax dollars or the Company will pay the Employee's share of the cost of such retroactive coverage.

If the Employee does not notify the Administrator within 30 days of the birth of a new eligible dependent, the Employee may not add the new eligible Section 152 Dependent to their coverage until the next open annual enrollment period or the next time a special enrollment rule (or other qualifying election change event, as set forth in Section 5.06) is triggered. Notwithstanding the foregoing, even if notice is not timely provided, if the Employee has elected a coverage under the Plan for which the premiums would not be changed if the new Dependent

were added to coverage, the Employee may add the new eligible Section 152 Dependent to their Plan coverage, but the coverage will become effective the date the Employee notifies the Administrator of the child's birth In any event, the Employee must notify the Administrator within 60 days following the event.

(c) Eligibility for State Assistance. Notwithstanding anything in the Plan to the contrary, an Employee may also enroll for health coverage under a HIPAA Program for the Employee and their eligible Section 152 Dependents if the Employee or Section 152 Dependent (i) becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a State Child Health Plan with respect to coverage under the Plan, or (ii) is covered under a plan offered under Medicaid or a State Child Health Plan and such coverage is terminated as the result of a loss of eligibility; provided that the Employee requests coverage under the Plan not later than 60 days after the date the Employee or Section 152 Dependent is determined to be eligible for such assistance. Such coverage will be effective as soon as administratively practicable following the completed election.

Section 5.06 Modifying and Revoking Elections. Except as provided in this Section 5.06, a Participant's election made under this Article will be irrevocable after it is filed with the Administrator; provided, however, that if a Participant fails to make required contributions, their election will be deemed to have been revoked, and benefits will cease.

(a) Change in Status. An Employee may revoke their election for the Plan Year and make a new election with respect to adding or dropping coverage if they experience a Change in Status and the election change is consistent with the Change in Status. An Employee may not use the Change in Status to switch between providers, programs or plans unless the change is consistent with the Change in Status. An election change must be on account of, and correspond with, a Change in Status that affects eligibility for coverage under said Benefit Program. With respect to an Employee's election to contribute to a Dependent Care Spending Account, an election change may be made where a Change in Status affects Dependent Care Expenses. The Administrator (in its sole discretion) will determine based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status.

(b) QMCSOs. The Administrator will be permitted to modify an Employee's election to provide coverage under an accident or health plan for a child or foster child who is a dependent of the Employee if a judgment decree or order resulting from divorce, legal separation, annulment or change in legal custody (including a QMCSO) requires coverage for the child. An Employee will be permitted to revoke their election for the Plan Year and make a new election to provide for or cancel coverage for the child if the order requires the Spouse, former Spouse or other individual to provide coverage for the child. The Administrator, in its sole discretion, will determine whether the order qualifies as a QMCSO in accordance with procedures established for such purpose. The Employee's new election will take effect as of the effective date provided in the QMCSO Procedures established by the Administrator.

(c) Medicare or Medicaid Entitlement. If an Employee or their Section 152 Dependent receiving coverage under a Benefit Program becomes enrolled for coverage under Medicare or Medicaid (other than coverage under a program solely providing pediatric vaccinations), the Employee may cancel or reduce coverage prospectively for that individual under an accident or

health plan. In addition, if an Employee or Section 152 Dependent is enrolled in but then becomes ineligible for Medicare or Medicaid coverage, the Employee may prospectively make a new election to commence or increase coverage for that individual under an accident or health plan.

(d) Change in Cost. *The following rules are not applicable to a Health Care Spending Account under the Plan.* For purposes of this Section 5.06(d), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, a health flexible spending arrangement (health FSA) is not similar coverage with respect to a health plan that is not a health FSA; an HMO and PPO are considered to be similar coverage; and coverage by another employer, such as a Spouse's or Section 152 Dependent's employer, is treated as similar coverage.

(i) Insignificant Cost Changes. Participants are required to increase their elective contributions to reflect insignificant increases in their required contribution for elected Benefit Programs, and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including, but not limited to, the dollar amount or percentage of the cost change. The Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected Employees' elective contributions on a prospective basis.

(ii) Significant Cost Increases. If the Administrator determines that the cost charged to an Employee of a Participant's Benefit Program option significantly increases during a Plan Year, the Participant may (a) make a corresponding prospective increase in their elective contributions; (b) revoke their election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another option available and offered under the Benefit Program that provides similar coverage; or (c) revoke their election and drop coverage prospectively if there is no other coverage option available that provides similar coverage. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(iii) Significant Cost Decreases. If the Administrator determines that the cost of any Benefit Program option significantly decreases during a Plan Year, the Administrator may permit the following election changes: (a) Participants who are enrolled in a coverage option may change their election on a prospective basis to elect the Benefit Program option that has decreased in cost; and (b) Employees who are otherwise eligible may elect the Benefit Program option that has decreased in cost on a prospective basis; subject to the terms and limitations of the Benefit Program option. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide

whether a cost decrease is significant in accordance with prevailing IRS guidance.

(e) Change in Coverage. *The following rules are not applicable to a Health Care Spending Account under the Plan.* The definition of "similar coverage" under Section 5.06(d) applies also to this Section 5.06(e).

(i) Significant Curtailment. If coverage is "significantly curtailed" (as defined in subsection (A) below), Participants may elect coverage under another Benefit Program option that provides similar coverage. In addition, as set forth in subsection (B) below, if the coverage curtailment results in a "Loss of Coverage" (as defined in subsection (C) below), Participants may drop coverage if no similar coverage is offered. The Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(A) Significant Curtailment Without Loss of Coverage. If the Administrator determines that a Participant's coverage under a Benefit Program option under this Plan (or the Participant's Spouse's or Section 152 Dependent's coverage under their own employer's plan) is significantly curtailed without a Loss of Coverage during a Plan Year, the Participant may revoke their election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Program option that provides similar coverage. Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(B) Significant Curtailment With a Loss of Coverage. If the Administrator determines that a Participant's Benefit Program option coverage under this Plan (or the Participant's Spouse's or Section 152 Dependent's coverage under their own employer's plan) is significantly curtailed, and such curtailment results in a Loss of Coverage during a Plan Year, the Participant may revoke their election for the affected coverage, and may either prospectively elect coverage under another Benefit Program option that provides similar coverage, or drop coverage if no other Benefit Program option providing similar coverage is offered.

(C) Definition of Loss of Coverage. For purposes of this Section 5.06(e)(i), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Program option, an HMO ceasing to be available where the Participant or their Spouse or Section 152 Dependent resides, or a Participant or their Spouse or Section 152 Dependent losing all coverage under the Benefit

Program option by reason of an overall lifetime or annual limitation). In addition, the Administrator in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under a health plan coverage option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in a PPO or an HMO);

- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or their Spouse or Section 152 Dependent is currently in a course of treatment; or

- any other similar fundamental loss of coverage.

(ii) Addition or Significant Improvement of a Health Plan Option. If during a Plan Year, a new Benefit Program option is added or an existing Benefit Program option is significantly improved, the Administrator may permit an election change to salary reductions if: (1) Participants who are enrolled in a Benefit Program option other than the newly-added or significantly improved Benefit Program option change their election on a prospective basis to elect the newly-added or significantly improved Benefit Program option; and (2) Employees who are otherwise eligible elect the newly-added or significantly improved Benefit Program option on a prospective basis; subject to the terms and limitations of the Benefit Program option. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Program option in accordance with prevailing IRS guidance.

(iii) Loss of Coverage Under Other Group Health Coverage. A Participant may prospectively change their election to add group health coverage for the Participant or their Spouse or Section 152 Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a State Child Health Plan; a medical care program of an Indian Tribal government (as defined in Section 7701(a)(40) of the Code), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Program option(s).

(iv) Change in Coverage Under Another Employer Plan. A Participant may make a prospective election change that is on account of and corresponds

with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Section 152 Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Plan Year that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during the Spouse's own employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

(f) Loss of Governmental or Educational Institution Sponsored Coverage. An Employee may make an election to participate in a Benefit Program if the Employee or their Section 152 Dependent loses coverage under any group health program sponsored by a governmental or educational institution.

(g) Unpaid FMLA Leave. An Employee taking an unpaid FMLA leave may revoke an existing election for the remaining portion of the Plan Year. Employees on unpaid FMLA leave will have the right to enroll in the Plan or change their election while they are on leave in the same manner as active Employees, rather than having to wait until returning to work. These rights will be in addition to any right to change an election under paragraphs (a) through (f) above. See Sections 3.06(b), 7.03(b) and 8.03(b) for special rules that apply to unpaid FMLA leave.

(h) COBRA. If an Employee or their Covered Dependent becomes eligible for COBRA continuation coverage under the Plan and the Employee continues to receive Compensation, the Employee may elect to increase their Contributions under the Plan to pay for the COBRA continuation coverage.

(i) HIPAA Special Enrollment Rights. An Employee who acquires special enrollment rights under HIPAA may revoke their previous Benefit Program elections for the Plan Year and make a new election that corresponds with such enrollment rights, regardless of whether the HIPAA special enrollment also qualifies as a Change in Status. The Employee's new benefit election will take effect no later than on the date that coverage for the special enrollment is effective under HIPAA, as applicable. With respect to the applicable Benefit Program(s), this subsection will be administered in accordance with Section 5.05.

(j) Changes Related to Affordable Care Act and/or Marketplace Coverage. An Employee may revoke their previous Benefit Program election for the remainder of the Plan Year if:

(i) Reduction in Hours of Service. The Employee, who had been reasonably expected to average at least 30 hours of service per week, experiences a change in their employment status such that they are reasonably expected to average less than 30 hours of service per week after the change, even if that

reduction does not result in their ceasing to be eligible under the applicable Benefit Program; provided that revocation of the election of coverage under the Benefit Program corresponds to the intended enrollment of the Employee (and any related Dependents who also cease coverage due to the revocation) in another plan that provides Minimum Essential Coverage, with the new coverage effective no later than the first day of the second month following the month that includes the date the coverage under the Benefit Program is revoked.

(ii) Enrollment of Employee in a Qualified Health Plan. The Employee is eligible for a special enrollment period to enroll in a Qualified Health Plan through a Health Insurance Marketplace (Marketplace) pursuant to guidance issued by the Department of Health and Human Services (e.g., at 45 C.F.R. § 155.420(d)) and any other applicable guidance, or the Employee seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; provided that revocation of the election of coverage under the Benefit Program corresponds to the intended enrollment of the Employee (and any related Dependents who also cease coverage due to the revocation) in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of coverage under the Benefit Program. Notwithstanding anything to the contrary in Section 5.06(j), an Employee's election change pursuant to this subsection will be effective as of the date immediately before the first date of coverage under the Qualified Health Plan.

(iii) Enrollment of Employee's Dependent(s) (Related Individual(s)) in a Qualified Health Plan. One or more of the Employee's covered Dependents ("Related Individuals," within the meaning of IRS Notice 2022-41) is/are eligible for a special enrollment period to enroll in a Qualified Health Plan through a Health Insurance Marketplace (Marketplace) pursuant to guidance issued by the Department of Health and Human Services (e.g., at 45 C.F.R. § 155.420(d)) and any other applicable guidance, or one or more already covered Dependents seek(s) to enroll in a Qualified Health Plan during the Marketplace's annual open enrollment period; provided that revocation of the election of coverage under the Benefit Program corresponds to the intended enrollment of the Dependent(s) (and any Related Individuals who also cease coverage due to the revocation) in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of coverage under the Benefit Program. If the Employee does not enroll in the Qualified Health Plan through a Marketplace as described in this subsection, the Employee must elect self-only coverage (or family coverage including one or more already-covered Dependents) under the Benefit Program. Notwithstanding anything to the contrary in Section 5.06(j), an Employee's election change pursuant to this subsection will be effective as of the date immediately before the first date of coverage under the Qualified Health Plan.

For purposes of this Section 5.06(j), the term Benefit Program shall only include "group health plan" coverage (i.e., an employee welfare benefit plan within the meaning of Section 3(1) of ERISA to the extent that such plan provides medical care within the meaning of Section 733(a) of ERISA), and to the extent such Benefit Program constitutes Minimum Essential Coverage. Election changes under this Section 5.06(j) shall only be permitted to the extent such changes (including the termination of coverage under this Benefit Program) are consistent with IRS Notice 2014-55 and/or IRS Notice 2022-41, as applicable, and any subsequent regulations; and, consistent with such guidance and to the extent permitted therein, the Administrator may rely on the reasonable representation of an Employee with respect to the Employee's and/or Related Individuals' (as applicable) enrollment or intent to enroll in the other Minimum Essential Coverage or Qualified Health Plan and the effective date of such enrollment. Capitalized terms used in this Section 5.06(j) but not otherwise defined shall have the same meaning as in IRS Notice 2014-55 and/or IRS Notice 2022-41, as applicable; provided, however, that references to the "Health Insurance Marketplace" and "Marketplace" shall include the term "Health Insurance Exchange" and "Exchange" within the meaning of such guidance.

(k) Domestic Partners. If a Domestic Partner is not a Section 152 Dependent, then group health coverage for the Domestic Partner is not provided under the Cafeteria Program. Nonetheless, benefit changes corresponding to the commencement or termination of a domestic partnership will be limited to those instances described herein for benefit changes corresponding to marriage or divorce.

(l) Procedure for Modifying Election. An Employee will make election changes under this Article by filing a new Election Form with the Administrator within 30 days (or such longer time as the Administrator may allow) after the date of the applicable event described in the applicable subsection.

(m) Effective Date of Modified Election. Except as provided below, an Employee's election changes pursuant to this Section 5.06 and new contribution levels will become effective as soon as administratively practicable following the date the Employee submits a completed Election Form with the Administrator.

(n) Becoming Ineligible. Upon the Administrator receiving notice that an Employee, Spouse or Dependent has lost eligibility under an underlying plan, the Administrator will automatically change the Participant's election either retroactively, as of the date the individual becomes ineligible for coverage in which case the Employee's contributions attributable to such coverage will be refunded to the Employee and any benefits paid recouped, or prospectively.

(o) Other Events. In the sole discretion of the Administrator, an Employee may be permitted to revoke or change an election upon any other event recognized for purposes of changing Plan elections under applicable law and regulations.

Section 5.07 Nondiscrimination Requirements.

(a) The Administrator may periodically conduct such testing as it deems necessary to comply with the applicable nondiscrimination requirements under the Code, including Sections 79, 105(h), 125, 129, 137, 223 and 9815 thereunder. The Administrator has the right to adjust any

Participant's Compensation reduction election made under this Article at any time and from time to time (i) to ensure that the Plan complies with any applicable nondiscrimination requirements of the Code referenced above, and (ii) to rectify erroneous Compensation reductions, contributions and credits.

(b) The Plan will not provide any statutory non-taxable benefits in a Plan Year to key employees (as defined in Section 416(i)(1) of the Code) in excess of 25 percent of the aggregate of such benefits provided to all Employees under the Plan. For purposes of the preceding sentence, qualified benefits will not include benefits which (without regard to this Section) are includable in the Participant's gross income.

(c) For purposes of this Section, statutory non-taxable benefits include "qualified benefits" (as defined in Section 125(f) of the Code and applicable regulations) that are excluded from income. Statutory non-taxable benefits also include group-term life insurance on the life of an Employee includable in the Employee's gross income solely because the coverage exceeds the limit in Section 79(a) of the Code.

ARTICLE VI
FUNDING AND ACCOUNTS

Section 6.01 Funding, Trust Agreements, and Insurance.

(a) The Benefit Programs may (but are not required to) be funded through the use of one or more trusts (including, where applicable, one or more trusts meeting the requirements of Section 501(c)(9) of the Code), Insurance Company contracts, or otherwise, in accordance with the various documents forming part of the Plan and the respective Benefit Programs. The benefits provided by the Benefit Programs will be supported by the contributions of the Employer, Participants and covered Dependents, as the case may be, in accordance with the Program Documents for the respective Benefit Programs. To the extent that a trust (via a trust agreement) or insurance contract funds part or all of the benefits provided by a particular Benefit Program, such agreement or contract will be deemed part of the Plan and incorporated herein by this reference.

(b) An Employer will have the right to enter into a contract with one or more Insurance Companies for the purposes of providing any benefits under the Plan and to replace any of such Insurance Companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract will not be assets of the Plan but will be the property of, and will be retained by, the Employer to the extent permitted by law. In the event that amounts are attributable to employee contributions or are required to be treated as Plan assets by law, the Administrator will make a reasonable determination as to how to apply such refunds. The Employer will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided by this Plan, including, but not be limited to, losses or obligations which pertain to the following:

(i) Once insurance is applied for or obtained, an Employer will not be liable for any loss that may result from the failure to pay premiums to the extent premium notices are not received by the Employer.

(ii) To the extent premium notices are received by an Employer, the Employer'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) An Employer will not be liable for the payment of any insurance premium or any loss that may result from the failure to pay an insurance premium if Participant contributions (if any) are not enough to provide for such premium cost at the time it is due. In such circumstances, the Employee will be responsible for and see to the payment of such premiums. The Employer will undertake to notify a Participant if Participant contributions under this Plan are not enough to provide for an insurance premium and that such policy will terminate if the Participants do not see to the payment of such premiums, but will not be liable for any failure to make such notification.

(iv) When employment ends, an Employer 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 an Employer will not be liable for or responsible to see to the payment of any premium after employment ends.

Section 6.02 Benefits Supported Only by Benefit Program. Any person having any claim under a Benefit Program will look solely to the assets of the Benefit Program, if any, for satisfaction. In no event will the Employer, any officers or agents thereof, or any member of the board of directors or other governing body be liable to any person under the provisions of the Benefit Program.

Section 6.03 Rights of Participants. No Participant will have any right to any amount credited to their Account at any time, except as follows:

(a) the right to have such credits applied toward the cost of coverage for their Benefit Program in accordance with this Plan; and

(b) the right to have any excess amounts that were deducted from their Compensation and credited to their Account by mistake of the Administrator restored to them as though part of Compensation. Such restoration will be made only if: (i) the Participant so requests in writing received by Administrator within one year after the mistaken credit was made; and (ii) the mistaken amount has not already been applied toward the cost of coverage for their elected Benefit Program. If such restoration cannot be made solely due to clause (ii), then the Employer may adjust the Participant's future Compensation reductions under the Plan to rectify the prior mistake. No interest will accrue or be owed to any Participant with respect to any restoration of Compensation under this Section.

ARTICLE VII
HEALTH CARE SPENDING ACCOUNT

Section 7.01 Type of Benefit. Pursuant to Article V, a Participant may elect to contribute a portion of their Compensation to a Health Care Spending Account on a pre-tax basis. The amounts contributed to the Health Care Spending Account are then used to reimburse the Participant for Medical Care Expenses. The Health Care Spending Account is intended to be a self-insured medical reimbursement plan within the meaning of Section 105(h) of the Code and a flexible spending arrangement within the meaning of Proposed Treasury Regulations at 26 C.F.R. § 1.125-5. The Employers and the Administrator will take whatever steps necessary to maintain and operate the Health Care Spending Account in accordance with the nondiscrimination requirements of Sections 105(h) and 125 of the Code. Any Participant who is enrolled in a High Deductible Health Plan, and so may contribute to an HSA, shall not be eligible to participate in the Health Care Spending Account but may participate in the Limited Health Care Spending Account. Such Limited Health Care Spending Account will reimburse Medical Care Expenses as provided in Section 7.04, but limited to the Medical Care Expenses as applicable for a Limited Health Care Spending Account only (see Section 2.45).

Section 7.02 Maximum Contribution. The minimum (if any) and maximum amounts a Participant may elect to contribute to a Health Care Spending Account will be determined by the Company each year and communicated to Participants in the annual enrollment materials; provided, however, that in no event will such maximum amount exceed the limit set forth in Section 125(i)(1) of the Code, as adjusted for inflation in accordance with the rules of Section 125(i)(2) of the Code (which, for 2025, is $3,300).

Section 7.03 Benefits After Termination and Reinstatement After Return.

(a) A Participant in the Health Care Spending Account who terminates employment and who does not elect continuation coverage as provided for herein, will be deemed to have revoked their participation under the Health Care Spending Account. Such former Employee will continue to be eligible to claim reimbursement for expenses incurred before the effective date of the former Employee's termination of employment or, if later, the end of the period of coverage for which the last contribution has been made. A Participant in the Health Care Spending Account who goes on a Leave of Absence will be deemed to have continued participation in the Health Care Spending Account unless the Participant elects otherwise. In such event, the Employee will continue to be eligible to claim reimbursement for expenses incurred before the effective date of the Employee's Leave of Absence.

(b) In the event an Employee does not have coverage under the Health Care Spending Account during FMLA leave (because the Employee chooses to revoke coverage or does not pay the required employee contributions for any reason during FMLA leave), upon returning from FMLA leave, the Employer will reinstate the Participant's Health Care Spending Account coverage. Upon reinstatement of coverage, the Participant may choose to:

(i) reinstate their per pay period deduction under the Health Care Spending Account, in which case the Participant's elected annual Participant

Contributions will be prorated for the period during which no contributions were paid, and reduced by prior reimbursements; or

(ii) resume Participant Contributions at the same annual contribution level, in which case the Participant's per pay period deduction under the Health Care Spending Account will be adjusted to an amount equal to the annual Participant Contributions less the actual Participant Contributions, divided by the number of pay periods remaining in the Plan Year. Notwithstanding the preceding provisions of this subparagraph (ii), if the Plan has already made disbursements to the Participant that exceed the Participant Contributions that will be paid for the Plan Year, the Employer may not require the Employee to pay any more than the remaining Participant Contributions due.

In no event will reimbursements be permitted for any otherwise eligible Medical Care Expenses during such Leave.

(c) If the Health Care Spending Account coverage continues during the FMLA leave, the Participant's contributions will continue as though the Participant is not on a Leave of Absence.

Section 7.04 Medical Care Expenses. Each Participant will be entitled to reimbursement from their Health Care Spending Account for Medical Care Expenses incurred during a Plan Year.

Section 7.05 Claim and Payment Procedures. The entire amount a Participant elects to contribute to their Health Care Spending Account for the year, less any reimbursements made from the Account for the year, will be available at all times during the period of coverage. A Participant must file claims for reimbursement of Medical Care Expenses from their Health Care Spending Account to the Claims Administrator in the manner prescribed by the Claims Administrator. Properly submitted claims will be paid monthly or when the total amount of the claims submitted is at least the minimum amount specified by the Administrator. Claims will be honored only if:

(a) incurred for Medical Care Expenses of the Participant or their Section 152 Dependent;

(b) incurred for treatment rendered while the recipient was covered by the Health Care Spending Account; and

(c) substantiated by (A) a written statement from an independent third party (such as the service provider) stating that the expense was incurred, identifying the treatment or service provided, the date of service, and the amount of the expense; and (B) a written statement from the Participant that the expense has not been reimbursed and is not reimbursable from any other source of coverage. If an explanation of benefits is submitted indicating the date of the service and the amount the Participant is responsible to pay, together with the statement described in (B) above, the claim will be deemed fully substantiated.

For this purpose, a Participant or Section 152 Dependent has incurred a Medical Care Expense when they receive the medical care that gives rise to the Medical Care Expense, regardless of when the Participant or their Section 152 Dependent is formally billed or charged for, or pays

the Medical Care Expense. Notwithstanding the foregoing, the Health Care Spending Account may pay or reimburse certain advance payments actually made by the Participant or their Section 152 Dependent (e.g., for orthodontia services) in order to receive such services to the extent permitted by Proposed Treasury Regulations at 26 C.F.R. § 125-5(k)(3)(i), and in accordance with the rules of the Claims Administrator.

Payments pursuant to this Section will be made only to Participants, and no payment will be made directly to the provider of the medical care services, treatment or supplies.

Section 7.06 Electronic Card Reimbursement. The Administrator may make available a "payment card" or "card" (i.e., a "debit card" within the meaning of Proposed Treasury Regulations at 26 C.F.R. § 1.125-6(b)(6), which includes a debit card, credit card, or stored value card) to enable Participants to pay for eligible Medical Care Expenses under the Plan at the point of purchase. In addition to the requirements generally applicable to Health Care Spending Accounts under the Plan, payment cards issued under the Plan will be subject to the following:

(a) Participant Certification. Each Participant who is issued a payment card under the Plan will certify upon enrollment in the Plan and each Plan Year thereafter, that: (i) the payment card will only be used to pay for eligible Medical Care Expenses for the Participant and/or the Participant's Dependent, (ii) the eligible Medical Care Expenses paid with the card have not been reimbursed and that the Participant will not seek reimbursement under any other plan covering health benefits, and (iii) sufficient documentation (including invoices and receipts) for any expense paid with the card will be acquired and retained. The Participant's certification will be deemed to be reaffirmed each time the card is used.

(b) Substantiation. All Medical Care Expenses paid or reimbursed through the use of a payment card will be substantiated in accordance with the requirements and guidance issued by the IRS including, without limitation, in Proposed Treasury Regulations at 26 C.F.R. § 1.125-6(e).

(c) Amount of Coverage. A Participant's use of a payment card will be limited to the amount credited to such Participant's Health Care Spending Account. Any Medical Care Expense incurred in excess of such amount will not be paid by the Plan. Merchants or service providers accepting the payment card issued under the Plan will be paid the full amount of the charge, subject to the Participant's Health Care Spending Account balance, and such Participant's Health Care Spending Account balance will be reduced by the corresponding amount.

(d) Scope of Use. Participants issued a payment card under the Plan will only be permitted to use it at merchants or service providers authorized by the Plan, and use of such card will be limited to: (i) physicians, dentists, vision care offices and hospitals and other medical care providers (as identified by the merchant category code); (ii) stores with the merchant category code for Drug Stores and Pharmacies if, on a location by location basis, 90% of the store's gross receipts during the prior taxable year consisted of items which qualify as Medical Care Expenses; and (iii) stores that have implemented an inventory information approval system that operates in accordance with applicable regulations and other guidance issued by the IRS.

(e) Ineligible Reimbursement. In the event any claim that has been reimbursed is subsequently identified as not qualifying for reimbursement, the following correction procedures with respect to the improper charge will apply:

(i) Upon identifying an improper payment, the Participant will be required to pay back to the Plan an amount equal to the improper payment.

(ii) Until the amount of the improper payment is recovered, the card must be deactivated.

(iii) If the Participant fails to pay back the improper payment as provided immediately above, the Participant will have the amount of the improper payment withheld from their wages or other compensation to the extent consistent with applicable law.

(iv) If the improper payment may not be corrected as provided in subsections (i) and (iii) immediately above, a claims substitution or offset approach will be used to resolve the improper payment.

(v) If the improper payment may not be corrected as provided in subsection (i), (iii) or (iv) immediately above, the Participant will be deemed to remain indebted to the Plan and the Plan will, consistent with its normal and customary practices, treat such indebtedness as it would any other indebtedness.

(f) No Card Requirement. Notwithstanding anything herein to the contrary, a Participant will not be required to use or obtain a payment card to obtain benefits under the Plan.

(g) Other Requirements. The Administrator is authorized to adopt, from time to time, such other reasonable administrative procedures and requirements as may reasonably be deemed necessary or appropriate to facilitate the payment card program under the Plan, provided such procedures and requirements are not materially inconsistent with the terms of the Plan and applicable law. All such procedures and requirements are hereby fully incorporated into, and will be deemed to be an integral part of, the Plan.

Section 7.07 Use It or Lose It Rule; Carryover Feature; Forfeitures.

(a) Use It or Lose It Rule. Claims received by the Administrator after the 60-day deadline immediately following the close of the prior Plan Year for expenses incurred during that closed Plan Year will be untimely and not eligible for reimbursement under the Plan. A Participant or former Participant will not be entitled to receive cash or any other form of compensation or benefits with respect to any unused balance in their Health Care Spending Account after all timely claims have been processed as of the end of a Plan Year, except as specifically provided in subsection (b) below. Similarly, no balance remaining after the expiration of the period for submitting claims for a Plan Year will be carried forward into any succeeding Plan Year, except as specifically provided in subsection (b) below.

(b) Carryover Feature.

(i) In General. Notwithstanding anything in this Article or the Cafeteria Program to the contrary, if any balance remains in the Participant's Health Care Spending Account with respect to a Plan Year after all claims hereunder, the amount of such balance, not to exceed the maximum set forth in subsection (ii) below, shall be carried over to reimburse the Participant for Medical Care Expenses incurred during the subsequent Plan Year. The carried-over balance shall not count against the Participant's maximum contribution determined in accordance with Section 7.02 above. The Company or Administrator may impose additional conditions on the availability of such carryover (e.g., a minimum balance available for carryover, required enrollment in the Health Care Spending Account during the subsequent Plan Year) to be applied on a uniform and consistent basis.

(ii) Maximum Carryover Amount. The maximum amount that may be carried over (and the conditions on the availability thereof, as described in the subsection immediately above) shall be set in advance of the Plan Year by the Company or Administrator, and shall be communicated to Participants in the enrollment materials for the applicable Plan Year; provided, however, that in no event will such maximum carryover amount exceed twenty percent (20%) of the maximum contribution permitted under Section 125(i)(2) of the Code for that Plan Year, as determined in accordance with IRS Notice 2020-33 and other applicable guidance.

(c) Use of Forfeitures. The Administrator will determine the aggregate forfeitures under the Health Care Spending Accounts for any particular Plan Year, and will, consistent with applicable law: (a) first, apply such forfeitures, insofar as possible, to offset any losses experienced by the Employer(s) as a result of making reimbursements in excess of contributions paid by all Participants and/or to pay the reasonable expenses of maintaining and administering the Plan; and (b) second, apply any remaining forfeitures for any legally permissible purpose(s) which may include, without limitation, to reduce required salary reduction amounts for the subsequent Plan Year on a reasonable and uniform basis.

ARTICLE VIII
DEPENDENT CARE SPENDING ACCOUNT

Section 8.01 Type of Benefit. Pursuant to Article V, a Participant may elect to contribute a portion of their Compensation to a Dependent Care Spending Account on a pre-tax basis. The amount contributed to the Dependent Care Spending Account is used to reimburse the Participant for Dependent Care Expenses as defined in Section 8.04. The Dependent Care Expense benefit is intended to be a dependent care assistance program within the meaning of Section 129 of the Code, and a flexible spending arrangement within the meaning of Proposed Treasury Regulations at 26 C.F.R. § 1.125-5, or subsequent guidance. The Employers and the Administrator will take whatever steps necessary to maintain and operate the Dependent Care Spending Account in accordance with the nondiscrimination requirements of Sections 129 and 125 of the Code.

Section 8.02 Maximum Contribution. The minimum and maximum amounts a Participant can elect to have contributed to their Dependent Care Spending Account will be determined by the Company each year and communicated to Participants in the annual enrollment materials; provided, however, that in no event will such amount exceed $5,000, or $2,500 for a married taxpayer filing as a single individual.

Section 8.03 Benefits During a Leave of Absence or After Termination.

(a) If a Participant ceases to be a Participant in this Dependent Care Spending Account for any reason during a Plan Year, the Participant's election to contribute to the Dependent Care Spending Account will terminate. The Participant will be entitled to reimbursement only for Dependent Care Expenses incurred within the same Plan Year and its related Grace Period prior to termination of employment, if the expenses are reimbursable under Section 8.04, and only if the Participant applies for such reimbursement in accordance with Section 8.06. No such reimbursement will exceed the remaining balance, if any, in the Participant's Dependent Care Spending Account for the Plan Year in which the expenses were incurred. In the event of the Participant's death, the Participant's spouse (or, if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements permitted under this Section.

(b) In the event a Participant does not have coverage under the Dependent Care Spending Account during FMLA leave (because the Participant chooses to revoke coverage or does not pay the required Participant Contributions for any reason during such leave), upon returning from such leave within the same Plan Year as such leave began, the Employer will reinstate the Participant's Dependent Care Spending Account coverage. Upon reinstatement of coverage, the Participant may choose to:

(i) reinstate their per pay period deduction under the Dependent Care Spending Account, in which case the Participant's elected annual Participant Contributions will be prorated for the period during which no contributions were paid, and reduced by prior reimbursements; or

(ii) resume Participant Contributions at the same annual contribution level, in which case the Participant's per pay period deduction under the Dependent

Care Spending Account will be adjusted to an amount equal to the annual Participant Contributions less the actual Participant Contributions, divided by the number of pay periods remaining in the Plan Year. Notwithstanding the provisions of this subparagraph (ii), if the Plan has already made disbursements to the Participant that exceed the Participant Contributions that will be paid for the Plan Year, the Employer may not require the Employee to pay any more than the remaining Participant Contributions due.

In no event will reimbursements be permitted for any otherwise eligible expenses incurred during such leave.

(c) If the Dependent Care Spending Account coverage continues during the FMLA leave, the Participant's contributions will continue as though the Participant is not on a Leave of Absence.

Section 8.04 Dependent Care Expenses. Each Participant will be entitled to reimbursement from their Dependent Care Spending Account for those Dependent Care Expenses incurred during a Plan Year and its related Grace Period that are eligible employment-related expenses under the child and dependent care credit provisions of Section 21(b)(2) of the Code and that do not exceed the earned income limit specified in Section 8.05, but only to the extent of the balance in the Participant's Dependent Care Spending Account when the claim is processed for such Plan Year or its related Grace Period.

The following rules (and any other applicable rules of Sections 21(b)(2) and 129 of the Code) apply in determining whether a Participant's expenses are for reimbursable "Dependent Care Expenses" under this Article:

(a) The expenses must be incurred to enable the Participant (and if the Participant is married, the Participant's Spouse) to be gainfully employed (or in active search of employment) during the period in which there is at least one qualifying individual (as defined in subsection (b) immediately below) in the Participant's household, and the expenses must be for either (i) expenses for household services that are attributable in part to the care of a qualifying individual, or (ii) expenses for the care of a qualifying individual. Educational expenses for a child in kindergarten or higher grade level are not payments for the care of a qualifying individual eligible for reimbursement.

(b) "Qualifying individuals" are any of the following persons:

(i) A Section 152 Dependent who has not attained age 13;

(ii) A Section 152 Dependent who is physically or mentally incapable of self-care and who regularly spends at least 8 hours per day in the Participant's household; or

(iii) A Spouse who is mentally or physically incapable of self-care and who regularly spends at least 8 hours per day in the Participant's household

With respect to (i) and (ii) above, a child will be a qualifying individual only with respect to a Participant who is the child's custodial parent (the parent with whom the child resided for the greater number of nights during the calendar year.

(c) This Plan will not reimburse a Participant for payments made to either (i) a child of the Participant if the child was under age 19 at the end of the Plan Year, or (ii) a person the Participant or the Participant's Spouse can claim as a dependent for federal income tax purposes.

Section 8.05 Earned Income Limit. For any Plan Year and its related Grace Period, reimbursement under this Plan for Dependent Care Expenses will not exceed the Participant's earned income limit calculated under the following rules. For purposes of this Section 8.05, "earned income" means the total wages, salary, and other Employee compensation and any net earnings from self-employment for the Plan Year.

(a) In the case of a Participant who is not married at the close of the Plan Year, the limit equals the Participant's earned income.

(b) In the case of a Participant who is married at the close of the Plan Year, the limit equals the lesser of the Participant's earned income or the earned income of the Participant's Spouse.

(c) During any month in the Plan Year, if the Participant's Spouse is either a full-time student at an educational institution or is physically or mentally incapable of self-care, the Spouse will be deemed to have "earned income" for that month in the applicable amount determined under the rules of Sections 129 and 21 of the Code (in 2025, this is $250 for one qualifying individual or $500 if there are at least two qualifying individuals (as defined in Section 8.04)).

(d) A married Participant who is legally separated or living apart will be considered not married if they are treated as not married under the rules of Sections 21(e)(3) and (4) of the Code.

Section 8.06 Claim and Payment Procedures. A Participant must file claims for reimbursement of eligible Dependent Care Expenses from their Dependent Care Spending Account with the Claims Administrator on the appropriate form furnished by the Claims Administrator. The Participant will be required to furnish receipts and statements from the providers of dependent care, but the Participant will complete the provider information section of the claim form and certify that this information is true.

All claims submitted by a Participant during a reimbursement period will be processed as of the end of that reimbursement period on the basis of the balance in the Participant's Dependent Care Spending Account for at the end of such reimbursement period. To the extent that any claims cannot be paid in full because credit in the Participant's Dependent Care Spending Account is insufficient to cover the claim, the claim will be held for payment in the next succeeding reimbursement period(s) of such Plan Year, but will not be carried over or charged against the balance of any subsequent Plan Year.

Payments pursuant to this Section will be made only to Participants, and no payment will be made directly to the provider of the dependent care.

Expenses incurred during a Plan Year's related Grace Period will be reimbursed from a Participant's Dependent Care Spending Account for such Plan Year, pursuant to this Section 8.06, so long as funds remain in the Participant's Dependent Care Spending Account for such Plan Year. After a Participant's Dependent Care Spending Account for such Plan Year has been exhausted, expenses incurred during the Grace Period may be reimbursed from the Participant's Dependent Care Spending Account for the Plan Year containing the Grace Period, if applicable, subject to the requirements set forth in this Section 8.06.

Section 8.07 Use It or Lose It Rule; Forfeitures.

(a) Use It or Lose It Rule. Claims received by the Administrator after the 60-day deadline immediately following the close of a Plan Year for expenses incurred during that closed Plan Year and its related Grace Period will be untimely and not eligible for reimbursement under the Plan. A Participant or former Participant will not be entitled to receive cash or any other form of compensation or benefits with respect to any unused balance in their Dependent Care Spending Account after all timely claims have been processed as of the end of a Plan Year and its related Grace Period. Similarly, no balance remaining after the expiration of the period for submitting claims for one Plan Year will be carried forward into any succeeding Plan Year.

(b) Use of Forfeitures. The Administrator will determine the aggregate forfeitures under the Dependent Care Spending Accounts for any particular Plan Year, and will, consistent with applicable law: (a) first, apply such forfeitures, insofar as possible to pay the reasonable expenses of maintaining and administering the Plan; and (b) second, apply any remaining forfeitures for any legally permissible purpose(s), which may include, without limitation, to reduce required salary reduction amounts for the subsequent Plan Year on a reasonable and uniform basis.

Section 8.08 Statements. On or before January 31 of each year, the Administrator will furnish to each Participant who has incurred dependent care assistance, including as provided in this Dependent Care Spending Account, during the preceding calendar year a written statement showing the amount of such dependent care assistance provided during such year, as required under Section 129(d)(7) of the Code. Such statement may be provided in any form and manner permitted in applicable guidance under the Code, including by causing the amount of dependent care assistance provided or elected to be reported on each such Participant's Form W-2 issued by the Participant's Employer.

ARTICLE IX
HEALTH SAVINGS ACCOUNT

Section 9.01 HSA Benefits. Participants who elect to participate in the High Deductible Health Plan coverage option will receive instructions on opening an HSA. The Employer may make contributions to an HSA on behalf of HSA-Eligible Individuals. A Participant may elect to make contributions to an HSA on a pre-tax salary reduction basis to the Participant's HSA established and maintained by a trustee/custodian to which the Company or Employer can forward contributions to be deposited. This "funding" feature constitutes the HSA Benefits offered under this Plan. Such election can be increased, decreased or revoked prospectively at any time during the Plan Year, generally to be effective no later than the first day of the next calendar month following the date that the election change was filed.

HSA Benefits cannot be elected with Health Care Spending Account (unless the Health Care Spending Account is a Limited Health Care Spending Account) benefits.

Section 9.02 Contributions for Cost of Coverage for HSA; Maximum Limits.

(a) In General. The annual contribution for a Participant's HSA Benefit shall be equal to the salary reduction contributions elected by the Participant plus Company or Employer contributions, if any, but in no event will the total contributions exceed the maximum set forth in Section 223(b) (as indexed in accordance with Section 223(g)) of the Code. The Company may establish rules and procedures governing a Participant's eligibility for an HSA contribution, as well as the timing and amount of Company or Employer contributions.

(b) Contribution Limit. Pursuant to Section 223(a) of the Code, the maximum allowable deductible contribution for a calendar year shall not exceed the sum of the monthly limitations in effect for the months during which the Participant is an HSA-Eligible Individual. The amount of the applicable monthly limitation depends on whether the Participant has (or is deemed to have) self-only or family coverage under a High Deductible Health Plan on the first day of the month. An additional catch-up contribution of $1,000 may be made for Participants who are age 55 or older.

(c) Full-Contribution Rule. Under the full-contribution rule, an individual who becomes covered under a High Deductible Health Plan in a month other than January (i.e., a midyear enrollee) and who is an HSA-Eligible Individual on December 1st of that year is treated as having been an HSA-Eligible Individual during every month of the year and will be allowed to make contributions (or to have them made on the individual's behalf) for those months during that year before the individual actually enrolled in a High Deductible Health Plan. Failure to remain HSA-Eligible during the immediately following 13-month period will cause the Participant to include the HSA contributions contributed in reliance upon this full-contribution rule in their federal gross income.

Section 9.03 Recording Contributions for HSA. The HSA is not a Company- or Employer-sponsored employee benefit plan—it is an individual trust or custodial account separately established by the Participant and maintained by a trustee or custodian outside the Plan. Consequently, the HSA trustee or custodian, not the Company or an Employer, will establish and

maintain the HSA. The HSA trustee or custodian will be chosen by the Company. The Administrator will maintain records to keep track of HSA contributions a Participant makes via pre-tax salary reductions, but it will not create a separate fund or otherwise segregate assets for this purpose. The Company has no authority or control over the funds deposited in a HSA, except that the Company (and/or Employer) reserves the right to recoup Company or Employer contributions (if any) in excess of the statutory maximum or contributions made on behalf of an individual who was never eligible to establish an HSA.

Section 9.04 Tax Treatment of HSA Contributions and Distributions. The tax treatment of the HSA (including contributions and distributions) is governed by Section 223 of the Code.

Section 9.05 Trust/Custodial Agreement; HSA Not Intended to Be an ERISA Plan. HSA Benefits under this Plan consist solely of the ability to make contributions to the HSA on a pre-tax salary reduction basis plus Employer contributions (if any). Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by the HSA trustee or custodian and the terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee or custodian to each electing Participant and are not a part of this Plan.

The HSA is not a Company- or Employer-sponsored employee benefit plan. It is a savings account that is established by the Participant and maintained by an HSA trustee or custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Section 223(d)(2) of the Code. The Company and any Employer have no authority or control over the funds deposited in a HSA. Even though this Plan may allow pre-tax salary reduction contributions to an HSA and provide for Company or Employer contributions to the HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Company or any Employer.

ARTICLE X
HEALTH REIMBURSEMENT ACCOUNT

Section 10.01 Type of Benefit Pursuant to this Article, the Plan may offer a Health Reimbursement Account integrated with one or more of its group health program offerings, subject to the terms of the applicable Benefit Program. Amounts are allocated to the Health Reimbursement Account of a Participant as provided under the applicable Benefit Program, and are then used to reimburse the Participant for Medical Care Expenses, in accordance with the applicable Benefit Program. The Employer is solely responsible for periodically funding the Health Reimbursement Account. Unused amounts in each Health Reimbursement Account will accrue from year to year at the Employer's sole discretion and may be revised prior to the commencement of each new Plan Year. No interest may be earned on unused balances.

Section 10.02 Maximum Contribution. The minimum (if any) and maximum amounts that may be allocated to a Health Reimbursement Account will be determined by the Company each year and communicated to Participants in the annual enrollment materials.

Section 10.03 Benefits After Termination. A Participant in the Health Reimbursement Account who terminates employment and who does not elect continuation coverage as provided for herein, will forfeit any amounts under the Health Reimbursement Account (except as may be provided for under any applicable retiree program for which the Participant is then eligible). Such former Employee will continue to be eligible to claim reimbursement for expenses incurred before the effective date of the former Employee's termination of employment.

Section 10.04 Claim and Payment Procedures. A Participant must file claims for reimbursement of Medical Care Expenses from their Health Reimbursement Account to the Claims Administrator in the manner prescribed by the Claims Administrator.

ARTICLE XI
SPECIAL COVERAGE PROVISIONS

Section 11.01 COBRA Continuation Coverage. This Section will only apply to Benefit Programs that would be considered a "group health plan" under Section 5000(b)(1) of the Code. Although not required by COBRA, the Plan will extend continuation coverage that is similar to COBRA to Domestic Partners in accordance with the terms of this Section 11.01. The rights provided to Domestic Partners shall be identical to those provided to spouses under this Section 11.01, except where otherwise noted and notwithstanding subsection (g)(iv) of this Section 12.01. Notwithstanding the foregoing, nothing in this Section 11.01 shall create a COBRA right or remedy for any such Domestic Partner. The Plan will offer continuation coverage to eligible Participants to the extent required by applicable state insurance law governing health insurance continuation.

(a) Qualifying Events. A Participant or qualified beneficiary who would otherwise lose group health plan coverage as a result of a "qualifying event," as defined below, will be entitled to elect continuation of group health plan coverage under the Benefit Program as provided by COBRA. The coverage will be identical to the coverage provided persons to whom a qualifying event has not occurred. If coverage is modified for individuals who have not incurred a qualifying event, continuation coverage will be modified in the same way for individuals who have elected COBRA continuation coverage. A "qualifying event" is any of the following:

(i) termination as an Employee (other than for gross misconduct) or reduction of hours worked so as to render the Participant ineligible for group health plan coverage under a Benefit Program, including termination of employment following a leave under FMLA;

(ii) the Participant's death;

(iii) divorce or legal separation of the Employee from their Spouse;

(iv) for a Spouse and Section 152 Dependent children, loss of coverage due to the Participant becoming entitled to Medicare; or

(v) for a Section 152 Dependent child, ceasing to qualify as an eligible Dependent under the applicable Benefit Program.

To lose coverage means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event; provided that if coverage is reduced or eliminated in anticipation of an event (e.g., in anticipation of a divorce), then the reduction or elimination is disregarded in determining whether an event would cause a loss of coverage.

(b) Qualified Beneficiary. For purposes of this Section 11.01, a "qualified beneficiary" includes a Participant's Section 152 Dependent child and/or Spouse who is a covered Dependent under a Benefit Program that is a group health plan subject to the requirements of COBRA on the day before a qualifying event, as provided in Section 4980B(g) of the Code. "Qualified beneficiary" will also include a child who is born to, adopted by or placed for adoption with the Participant during the period of COBRA continuation coverage, and who is enrolled in the Plan

by the Participant either (i) upon the child's birth, adoption or placement for adoption, provided the Participant notifies the Administrator in writing (or via an Election Form) within 30 days of the child's birth, adoption or placement for adoption; or (ii) during an annual enrollment period for the Plan.

(c) Notice to Administrator. The Administrator may establish reasonable procedures for providing the notices required by this Section 11.01(c).

(i) A Participant or their qualified beneficiary must notify the Administrator in writing (or via an Election Form) within 60 days after the later of:

(A) the date of a divorce or legal separation or the date an eligible Section 152 Dependent child will cease to qualify as an eligible Dependent under the applicable Benefit Program, or the date of a second qualifying event; or

(B) the date coverage would be lost as a result of the event; or

(C) the date on which the qualified beneficiary is informed of the responsibility to provide notice and the Plan's procedures for providing notice to the Administrator.

All rights to continued Benefit Program coverage will be lost by the failure to timely give this required written notice to the Administrator.

(ii) An eligible Participant may elect COBRA continuation coverage for an eligible child who is born to, adopted by, or placed for adoption with such Participant while the Participant's COBRA continuation coverage (or right to elect COBRA continuation coverage) is effective, provided that the Participant has notified the Administrator in writing (or via an Election Form) within 30 days of the child's birth, adoption, or placement for adoption.

(iii) An Employer will notify the Administrator of the following qualifying events within 30 days of the event or within 30 days following the date coverage ends if the Benefit Program provides that continuation coverage commences on the date coverage is lost:

(A) the Participant's death;

(B) termination or reduction in hours that the Participant works; or

(C) the Participant becoming entitled to Medicare.

(iv) A Participant or qualified beneficiary entitled to COBRA continuation coverage with a maximum duration of 18 months will notify the Administrator if found by the Social Security Administration to have been

disabled at any time during the first 60 days of continuation coverage. This notice must be given within 60 days after the latest of:

(A) the date of the disability determination by the Social Security Administration;

(B) the date on which the qualifying event occurred;

(C) the date on which the Participant or qualified beneficiary loses or would lose coverage under the Plan as a result of the qualifying event; or

(D) the date on which the Participant or qualified beneficiary is informed of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Administrator;

provided, however, that the notice is received before the end of the first 18 months of COBRA continuation coverage.

(v) A Participant or qualified beneficiary who has been found to have been disabled (as described in Section 11.01(c)(iv)) will notify the Administrator of a subsequent determination by the Social Security Administration that the individual is no longer disabled. This notice must be provided within 30 days after the later of:

(A) the date of the final determination by the Social Security Administration that the disabled individual is no longer disabled; or

(B) the date on which the disabled Participant or qualified beneficiary is informed of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Administrator.

(d) Notice to Participant and Qualified Beneficiary.

(i) The Administrator must advise the Participant and all qualified beneficiaries of the right to continue coverage not later than:

(A) 14 days after being notified of a qualifying event, or

(B) if the Employer is the Administrator, not later than 44 days after occurrence of the qualifying event or, if the Benefit Program provides that continuation coverage commences the date coverage is lost, not later than 44 days after the date coverage is lost.

(ii) If the Administrator receives a notice under Section 11.01(c) and the individual is not entitled to COBRA continuation coverage, the Administrator will provide notice to the individual that COBRA coverage is unavailable.

(iii) If COBRA coverage terminates earlier than the end of the maximum period described in Section 11.01(g), then the Administrator will provide notice to the Participant and their qualified beneficiary of the date of termination (in accordance with applicable regulations) as soon as possible following the Administrator's determination that coverage will terminate.

(iv) Notice of the right to continued coverage to a qualified beneficiary Spouse will be deemed notice to any qualified beneficiary children residing with such Spouse. Notwithstanding the preceding sentence, a single notice addressed to a Participant and Spouse may be provided under this Article, provided that the most recent information available to the Administrator indicates that both reside at the same address. Each qualified beneficiary that is a covered Section 152 Dependent child may be notified by providing a single notice to either the Participant or Spouse, provided that the most recent information available to the Administrator indicates that the Section 152 Dependent resides at the same address as the individual to whom notice was given. An election to receive or to waive coverage for a Section 152 Dependent child may be made by the Participant or their Spouse with whom the Section 152 Dependent child resides.

(e) Election of Coverage. If the Participant or qualified beneficiary does not elect continuation coverage within this election period, then the right to continuation coverage based on COBRA rules will be lost. Coverage must be elected within 60 days of the latest of the following:

(i) the qualifying event; or

(ii) the date the Participant or qualified beneficiary is advised by the Administrator of the right to continued coverage.

(f) Payment for Coverage.

(i) The Participant and/or qualified beneficiary will be required to pay up to 102% of the group rate for the continued coverage as determined by the Administrator and have the option to make these payments in monthly installments. Such monthly installment payments are due by the 30th day after the first day of the month for which payment is made. Installments that are paid later than such 30-day grace period will not be deemed timely and will result in coverage being terminated.

(ii) Contribution amounts and benefits for continuation coverage are subject to change. The Participant will be notified of any changes in contribution amounts or benefits available under the applicable Benefit Program.

(iii) If the Participant or qualified beneficiary elects continuation of coverage after the qualifying event, then the Participant or qualified beneficiary will have 45 days from the date of election to start paying for that coverage. The first payment must include the cost of coverage for the entire period from the date coverage was lost due to the qualifying event at least through the

date of payment. There is no grace period for the first payment. Subsequent monthly installment payments are due by the 30th day after the first day of the month for which payment was late. Installments that are paid after such 30 day grace period will not be deemed timely and will result in COBRA coverage being terminated.

(iv) The Benefit Program will not be required to bill covered individuals for continuation coverage. If any payment for continuation coverage is postmarked or otherwise sent after the date that payment is due, continuation coverage under the Benefit Program will terminate and will not be reinstated. An exception will be made for "insignificant underpayment" of a monthly installment. A payment will be deemed an insignificant underpayment provided that the deficiency is no greater than the lesser of:

(A) $50 or such other amount as the IRS Commissioner may provide; or

(B) 10% of the installment amount due.

In such a case, the Plan will notify the Participant of the deficiency, and the Participant will have 30 days from the date of such notice to pay the deficiency.

(g) Period of Coverage.

(i) If elected, the maximum period for continued coverage is as follows:

(A) 18 months from the date coverage is lost on account of a qualifying event involving termination of employment or reduction in hours; and

(B) 36 months from the date coverage is lost on account of any other qualifying event.

(ii) The maximum period described in subparagraph (i)(A) may be extended if:

(A) COBRA continuation coverage is triggered by the Participant's termination of employment or reduction in hours and either the Participant or qualified beneficiary is found by the Social Security Administration to have been disabled at any time during the first 60 days of continuation coverage, then the disabled person and their covered family members will be eligible for up to 29 months of continued coverage (an additional 11 months). The Administrator may assess an increased charge of up to 150% of the cost of Benefit Program coverage for the additional 11 months of coverage; or

(B) If a second qualifying event that gives rise to a 36-month maximum coverage period occurs within the applicable 18 or 29 month period,

the period of coverage may be extended up to 36 months from the date of the first qualifying event for the Participant's qualified beneficiary Spouse and qualified beneficiary child. This extended coverage period will be available when one of the following events occurs during such original period of continued coverage:

(1) the Participant's death;

(2) divorce or legal separation of the Participant from their qualified beneficiary Spouse; or

(3) for a qualified beneficiary child, ceasing to qualify as an eligible Dependent under the applicable Benefit Program.

To be eligible for this additional coverage, the Participant or their qualified beneficiary must notify the Administrator in writing (or via an Election Form) within 60 days of the second qualifying event and before the applicable 18 or 29 month period of continued coverage ends.

(iii) Coverage will end before the end of the maximum period on the first of the following, if any, to occur:

(A) the date all Employers cease to provide any group health plan coverage to any Employee;

(B) the date the Participant or qualified beneficiary fails to make any required installment contribution payment;

(C) the date that there has been a final determination by the Social Security Administration that the Participant or qualified beneficiary who has elected to extend coverage for up to 29 months due to disability is no longer disabled;

(D) the Employer terminates the Employee's coverage for cause (for example, submission of a fraudulent claim by the Employee); or

(E) the first day after the Participant or qualified beneficiary makes a COBRA election on which the Participant or qualified beneficiary, becomes:

(1) a covered employee or dependent under any other group health plan other than TRICARE or any other government-sponsored medical care program while that person is on a Leave of Absence under USERRA; or

(2) entitled to Medicare.

However, if the Participant or qualified beneficiary becomes covered by another group health plan and has a pre-existing condition that is not covered by that other plan, then COBRA coverage (at least for that pre-existing condition) will not be terminated due to such other coverage.

(iv) Continuation coverage is provided subject to eligibility under the law. The Administrator reserves the right to terminate continuation coverage retroactively if the individual is determined to be ineligible for continuation coverage. The Administrator intends to provide continuation coverage only to the extent required by law and will administer continuation coverage according to those requirements. This Section will not create any rights in excess of the minimum required by law.

(h) Health Care Spending Account. Notwithstanding any provision in the Plan to the contrary, COBRA continuation coverage as provided in this Section will not be provided under the Health Care Spending Account:

(i) for any Plan Year after the Plan Year in which the qualifying event occurs, with respect to any Participant or covered Section 152 Dependent, as long as:

(A) the benefits under the Health Care Spending Account are excepted benefits within the meaning of Sections 9831 and 9832 of the Code; and

(B) the cost of 12 months of COBRA continuation coverage under the Health Care Spending Account for the Plan Year in which the qualifying event occurs equals or exceeds the maximum benefit available to the Participant or covered Section 152 Dependent under the Health Care Spending Account for the Plan Year; and

(ii) for the Plan Year in which the qualifying event occurs, if as of the date of the qualifying event, such Participant or covered Section 152 Dependent cannot become entitled to receive during the remainder of such Plan Year a benefit under the Health Care Spending Account that exceeds the maximum amount that the Participant or covered Section 152 Dependent must pay for COBRA continuation coverage for the remainder of such Plan Year. For purposes of this item, in determining the amount of the benefit under the Health Care Spending Account that the Participant or covered Section 152 Dependent can become entitled to receive during the remainder of the Plan Year in which the qualifying event occurs, the Health Care Spending Account may deduct from the maximum benefit available to the Participant any reimbursable claims submitted to the Health Care Spending Account before the date the qualifying event occurred.

(i) Continuation Coverage After Relocation. If a Participant or qualified beneficiary relocates to an area not served by their region-specific health coverage benefit program or option, the Participant or qualified beneficiary will be given, within a reasonable period of time after requesting other coverage, an opportunity to elect alternative or extended coverage if there is another program or option available to Participants who have not experienced a qualifying event that will serve the Participant's or qualified beneficiary's health care needs. The alternative coverage must be effective as of the later of the date of the Participant's or qualified beneficiary's relocation, or the first of the month following the month in which the alternative coverage is requested.

(j) Annual Enrollment. In the event that an annual enrollment occurs during a period of COBRA continuation coverage, the affected Participant or qualified beneficiary will be given the same right that is provided to active Employees to choose other coverage or another benefit option under a group health plan under which they would otherwise be entitled to coverage under this Section.

(k) Trade Adjustment Assistance Rights. A Participant or Dependent who lost group health plan coverage as a result of the Participant's termination of employment and did not elect COBRA continuation coverage in connection with such loss will have a second opportunity to elect such coverage during the 60-day period that begins on the first day of the month in which the Participant becomes eligible for trade adjustment assistance ("TAA") under the provisions of the Trade Act of 2002, but only if such election is made not later than six months after the date of the Participant lost coverage due to the termination of employment that entitles them to TAA. To be eligible for this second election, the Participant or their Spouse must notify the Administrator in writing of such TAA eligibility within 60 days of the date the Participant becomes eligible for TAA. Coverage elected in accordance with this Section 11.01(k) will become effective at the beginning of the 60-day election period described above.

Section 11.02 Conversion of Coverage. Unless the Program Documents provide otherwise, the Plan will not provide conversion coverage; provided, however, that nothing in a Benefit Program will preclude a Participant from exercising any conversion option made available to them by an Insurance Company under an Insurance Company contract. Unless the Program Documents provide otherwise, neither the Administrator nor any Employer will have any obligation to provide notice of any such conversion option.

Section 11.03 Pre-existing Condition Limitation. There will be no pre-existing condition limitation under any HIPAA Program. Pre-existing condition limitations may apply to Benefit Programs, other than a HIPAA Program, to the extent provided by the Program Documents.

Section 11.04 Required Coverage. Notwithstanding anything contained in any Program Document to the contrary, the following provisions will apply to each applicable Benefit Program:

(a) Minimum Hospital Stay. To the extent required by the Newborns' and Mothers' Health Protection Act of 1996, each Benefit Program 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 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, the Benefit Program may not, under federal law, require that any provider obtain authorization from the Benefit Program for prescribing a length of stay not in excess or 48 hours (or 96 hours). A Benefit Program may require, as a condition of the Participant reducing their out-of-pocket costs, a Participant to notify it in advance of a hospital admission in connection with a childbirth. This subsection will not create any rights in excess of the minimum required by law.

(b) Parity in Mental Health and Substance Use Disorder Benefits. The Plan will comply with MHPAEA, to the extent MHPAEA is applicable to the Plan. Nothing in the Plan will be construed to require any Benefit Program to provide mental health and/or substance use disorder benefits. This subsection will not create any rights in excess of the minimum required by law.

(c) Benefits for Reconstructive Surgery Following Mastectomy. To the extent required by the Women's Health and Cancer Rights Act of 1998, each Benefit Program subject to that act will provide coverage to a Participant or Dependent who elects breast reconstruction in connection with a mastectomy for (i) all stages of reconstruction of the breast in which the mastectomy was performed; (ii) surgery and reconstruction of the other breast to produce symmetrical appearance; and (iii) prostheses; and (iv) physical complications of mastectomy, including lymph edemas. Such coverage will be provided in a manner determined in consultation with the treating physician and Participant or Dependent. This subsection will not create any rights in excess of the minimum required by law.

(d) Preventing Surprise Medical Bills. To the extent required by the Consolidated Appropriations Act, each Benefit Program subject thereto will cover (i) out-of-network "emergency services," (ii) out-of-network non-emergency services performed by out-of-network providers at certain in-network facilities, and (iii) out-of-network air ambulance services (if the Benefit Program covers in-network air ambulance services) at the levels required by, and subject to all applicable requirements of, the Consolidated Appropriations Act (e.g., via Sections 716 and 717 of ERISA and/or Sections 9816 and 9817 of the Code) and the rules of the Plan. This subsection will not create any rights in excess of the minimum required by law.

(e) Continuity of Care upon the Expiration of Provider Network Contract. To the extent required by the Consolidated Appropriations Act, each Benefit Program subject thereto will provide continued transitional care to a "continuing care patient" within the meaning of, and subject to the requirements of, the Consolidated Appropriations Act (e.g., via Section 718 of ERISA and/or Section 9818 of the Code, as applicable) and the rules of the Plan. This subsection will not create any rights in excess of the minimum required by law.

ARTICLE XII
COORDINATION OF BENEFITS AND RECOVERY OF BENEFIT OVERPAYMENT

Section 12.01 Coordination of Benefits. Except as specifically provided otherwise in an applicable Program Document, this Section will apply to the coordination of benefits with respect to any medical or other health benefit.

(a) General. The rules set forth in this Section coordinate the payment of benefits under the Plan with other group medical plans under which a Participant or covered Dependent is covered so that the Participant or covered Dependent receives all of the benefits to which they are entitled, but not to exceed 100% of total allowable expenses. When a claim is made, the order of benefit determination rules set forth below determine whether the Plan is a "primary plan" or a "secondary plan." When the Plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When the Plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits. No plan pays more than it would without the coordination provision.

(b) Definitions. For purposes of this Section, the following definitions will apply:

(i) An "allowable expense" means any necessary, reasonable health care service or expense, including deductibles and copayments, that is covered, at least in part, by any of the other group medical plans covering the person. When a plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service, or a portion thereof, that is not covered by any of the plans is not an allowable expense.

(ii) "Other group medical plans" means the following types of medical, dental and vision care benefits:

(A) coverage under a governmental program or provided or required by law, except a state Medicaid plan under Title XIX of the Social Security Act;

(B) group insurance or group-type coverage, whether insured or uninsured. This includes group or group type coverage under health maintenance organizations and other pre-payment group practice or individual practice coverage;

(C) group-type contracts that are contracts not available to the general public and that can be obtained and maintained only because of membership in or in connection with a particular organization or group; and

(D) medical benefits coverage under group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts.

Each contract or other arrangement is a separate group medical plan. If an arrangement has two parts and the coordination of benefit rules apply only to one of the two, each of the parts is a separate group medical plan.

(c) Order of Benefit Determination Rules. When two or more plans pay benefits, a plan without a coordinating provision is always the primary plan. If all plans have such a provision, the first of the following rules that describes which plan is primary will determine the order of payment:

(i) Non-Dependent or Dependent. The plan under which the individual is the eligible individual (rather than a covered Dependent) is primary and the other is secondary, unless such person is a Medicare beneficiary.

(ii) Child of Parents Not Separated or Divorced. If a covered Dependent child is covered under both parents' plans, the birthdays of the covered Dependent child's parents are used to determine which plan is primary. The plan of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be primary. If both parents have the same birthday, then the plan that has had coverage in effect for the covered Dependent child for the longest period of time is primary.

(iii) Child of Parents Separated or Divorced. If the parents are separated or divorced and a court order makes one parent responsible for the child's health care, the plan of that parent is primary. If there is no court order, the following will apply:

(A) the plan of the parent with custody is primary;

(B) the plan of the person married to the parent with custody (step-parent) is secondary; and

(C) the plan of the parent without custody pays third.

If neither paragraphs (i), (ii) or (iii) applies, the plan covering the individual for the longest period of time is primary.

(iv) Stepchild of a Participant or Child of a Domestic Partner. If a Participant's stepchild or the child of a Participant's Domestic Partner is also covered under a plan of the child's parent, the plan of the parent will be primary.

(v) Active or Inactive Employee. The plan that covers a person as an employee who is neither laid off nor retired (or as that person's dependent) is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(vi) Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member,

subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(vii) Longer or Shorter Length of Coverage. The plan that covered the person longer is primary.

(viii) Other Rules Do Not Apply. If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plans. In addition, the Plan will not pay more than it would have paid had it been primary.

(d) Right to Receive and Release Needed Information. Certain facts about health care coverage and services are needed to apply these coordination of benefits rules and to determine benefits payable under this Plan and other plans. A Covered Person will be required to give information about coverage under any other plans under which such individual is covered when they submit a claim for benefits under a Benefit Program. The Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Administrator need not tell, or get the consent of, any person to do this.

(e) Facility of Payment. A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

(f) Right of Recovery. If the amount of the payments made by the Administrator is more than it should have paid under this coordination of benefits provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Section 12.02 Medicare-Eligible Employees and Dependents. This Section will only apply to "medical benefits" (within the meaning of Medicare) provided under the Benefit Programs, and will apply to the full extent permitted by law.

(a) Each Medicare-eligible Employee covered by a Benefit Program providing medical benefits will continue to be covered by such Benefit Program, unless they refuse (in writing or via an Election Form) the medical benefits provided under such Benefit Program in favor of Medicare primary coverage.

(b) Each Medicare-eligible Dependent of an Employee covered by a Benefit Program providing medical benefits will continue to be covered by such Benefit Program, unless they refuse

(in writing or via an Election Form) the medical benefits provided under such Benefit Program in favor of Medicare (as primary) coverage.

(c) Notwithstanding anything in subsections (a) or (b) to the contrary, Medicare will automatically be the primary coverage for a Medicare-eligible Participant who is covered by an applicable Benefit Program and who:

(i) begins a regular course of renal dialysis;

(ii) receives a kidney transplant without first beginning dialysis; or

(iii) becomes disabled for Medicare purposes

at the earliest time at which Medicare is permitted to be primary under Section 1862(b) of the Social Security Act, regardless of whether such person actually enrolls for Medicare.

(d) To the extent permitted by law, Medicare will be the primary coverage for a Participant (other than an Employee) or Dependent who is covered by an applicable Benefit Program and who attains age 65.

Section 12.03 Subrogation, Reimbursement and Recovery for Third Party Liability. As a condition for receiving benefits under the Plan, each Covered Person agrees to and grants the Plan the right to subrogation, the right to reimbursement, and the right of recovery as set forth herein. When a Covered Person becomes sick or injured as a result of the act or omission of another person or party and the Covered Person received benefits under the Plan for such injuries, the Covered Person must reimburse the Plan for benefits received from all recoveries from a Third party (whether by lawsuit, settlement or otherwise) and the Plan's share of the recovery will not be reduced because the Covered Person has not received the full damages claims, unless the Plan agrees in writing to such a reduction. If the Covered Person breaches this Third Party reimbursement provision, then the Covered Person agrees to indemnify the Plan for all costs of recovering Third Party reimbursements. To the extent that any Program Document also contains provisions regarding subrogation, reimbursement, or right to recovery of expenses, this Section 12.03 and the applicable Program Document will both apply so as to grant the Plan the greatest possible rights with respect to subrogation, reimbursement, and recovery of such expenses or benefits. Except as specifically provided otherwise in an applicable Program Document, this Section 12.03 will apply to any health or disability benefit provided through the Benefit Programs.

(a) Right of Subrogation. As a condition to participation in or the receipt of benefits under the Plan, each Covered Person agrees that the Plan will have the right of subrogation with respect to the full amount of benefits paid to or on behalf of a Covered Person as the result of an injury, illness, disability or death that is or may be the responsibility of any Third Party. The Plan will also have a lien upon any recovery from such Third Party to the full amount of benefits paid and may, at its option, file suit or intervene in any pending lawsuit to secure and protect its rights. The Plan's right of subrogation will apply to the first dollar of any recovery obtained from the Third Party, even if the recovery obtained is less than the amount needed to make the Covered Person whole.

(b) Reimbursement Agreement. If a Covered Person incurs expenses that are excluded in accordance with this provision of the Plan because they are or may be the responsibility of a Third Party, the Covered Person will be required, as a prerequisite to receiving Plan benefits, to sign a reimbursement agreement in a form acceptable to the Administrator acknowledging the Covered Person's obligation to reimburse the Plan for any benefits or expenses paid by the Plan from the first dollars recovered from any source. If expenses are incurred by a minor, the Administrator may require that the minor's parent or legal guardian execute the reimbursement agreement and agree to be bound by it. The Administrator may, in its discretion, withhold benefit payments that might otherwise be advanced, and/or initiate an action at law or in equity in its own name or in the name of the Covered Person, in order to enforce, secure, or protect the Plan's rights under this provision. If the Covered Person elects not to execute such an agreement, the Plan is not obligated to provide any benefit payments.

(c) Right of Reimbursement. Whether or not a Covered Person executes a reimbursement agreement, in the event that the Plan provides benefits to a Covered Person and the Covered Person recovers a payment, either by settlement, judgment, no-fault automobile insurance statute, or otherwise, from any Third Party or other source, then the Covered Person will immediately reimburse the Plan for the full amount of any and all benefits paid in connection with such injury, illness, disability or death, up to the amount of the recovery. This right of reimbursement applies regardless of the label assigned to the recovery, and regardless of any purported allocation or itemization of such recovery to specific types of injuries. If the recovery is for damages other than for medical or dental care expenses, such as pain and suffering, the Covered Person will still be required to reimburse the Plan first. The Plan will have a lien upon any such recovery in the amount of benefits or expenses paid by the Plan. The Plan's right of reimbursement will apply to the first dollar of any recovery obtained from the Third Party, even if the recovery obtained is less than the amount needed to make the Covered Person whole.

(d) Procedures for Subrogation and Reimbursement. Each Covered Person or their legal representative must do whatever is requested by the Administrator with respect to the exercise of the subrogation and reimbursement rights of the Benefit Program and the Employers, and will do nothing to prejudice those rights. In addition, each Covered Person or their legal representative, in conjunction with making a claim for Benefit Program benefits, must inform the Administrator in writing whether the Covered Person was injured by a Third Party, and must provide the following information in a timely, prompt fashion as a condition to receipt of Benefit Program benefits:

(i) the name, address, and telephone number of the Third Party that in any way caused the injury, and of the attorney representing the Third Party;

(ii) the name, address, and telephone number of the Third Party's insurer and any insurer of the Covered Person;

(iii) the name, address, and telephone number of the Covered Person's attorney with respect to the Third Party's act;

(iv) prior to the meeting, the date, time and location of any meeting between the Third Party or their attorney and the Covered Person, or their attorney;

(v) all terms of any settlement offer made by the Third Party or their insurer or the Covered Person's insurer;

(vi) all information discovered by the Covered Person, or their attorney, concerning the insurance coverage of the Third Party;

(vii) the amount and location of any funds that are recovered by the Covered Person from the Third Party or their insurer or the Covered Person's insurer, and the date that the funds were received;

(viii) prior to settlement, all information related to any oral or written settlement agreement between the Covered Person and the Third Party or their insurer or the Covered Person's insurer;

(ix) all information regarding any legal action that has been brought on behalf of a Covered Person against the Third Party or their insurer; and

(x) all other information requested by the Administrator.

No Covered Person (or the person's legal representative) may retain an attorney with respect to the Third Party without the prior written consent of the Administrator. As a condition of receiving benefits under the Benefit Program, each Covered Person (and that person's legal representatives) hereby:

(i) waives the assertion of any attorney-client privilege against an Employer with regard to an attorney retained by the Covered Person;

(ii) agrees that an Employer may assume, at its discretion, the defense of any action that has been or could be brought against the Third Party by the Covered Person (or that person's legal representatives);

(iii) agrees that an Employer must be given the opportunity to approve any settlements before they are made with the Third Party;

(iv) agrees to consent to judgment for the Plan;

(v) agrees not to assert a defense under Section 502 of ERISA to a claim made by the Plan; and

(vi) agrees that a claim brought by the Plan to enforce its rights under this Section 12.03 is an equitable claim.

Any funds recovered by a Covered Person (or that person's legal representative) from a Third Party (or the Third Party's insurer) must and are deemed to be held in constructive trust for the benefit of the Benefit Program and the Employer to the extent of the amount of Benefit Program benefits until reimbursement, with the Covered Person (or that person's legal representative) as trustee and fiduciary.

(e) Coverage for Expenses Caused by a Third Party. The Administrator may, in its sole discretion, cease to pay benefits under a Benefit Program if a Covered Person refuses to execute a reimbursement agreement. The Administrator may cease to pay benefits subject to a reimbursement agreement if, in the discretion of the Administrator, the Covered Person has failed or is failing to fulfill their duty to cooperate or to comply with the provisions of this Section 12.03.

(f) Right of Recovery and Offset. The Plan will have the right to recover any benefits paid to a Covered Person or their health care provider that a Covered Person fails to reimburse to the Plan under the provisions of this Section 12.03. To the extent not otherwise paid to the Plan, the amount due to the Plan will reduce any other present or future benefits payable from the Plan to or on behalf of the Participant. In addition the Administrator may, in its sole discretion, employ any other lawful means to recover overpayment on behalf of the Plan. These rights are in addition to any other rights and remedies that the Plan may have.

(g) Attorneys' Fees and Expenses. The Benefit Program's right, and the amount to be reimbursed to the Benefit Program, will equal the amount of benefits the Covered Person received from the Benefit Program, adjusted by the Covered Person's reasonable share of attorneys' fees and costs to obtain payment from the Third Party, but will not exceed the amount the Participant actually received from the Third Party.

Section 12.04 Recovery of Benefit Overpayment. If any benefit from a Benefit Program paid to or on behalf of a Covered Person should not have been paid or should have been paid in a lesser amount, and the Covered Person or other recipient fails to repay the amount promptly, then the overpayment may be recovered by the Administrator to the extent permitted by law from any monies then payable, or which may become payable, in the form of salary, wages, or benefits payable under any Employer sponsored benefit programs, including the applicable Benefit Program. The Administrator also reserves the right to recover any such overpayment by appropriate legal action.

Section 12.05 Termination of Coverage for False Representations or Fraud. If any individual makes a false representation to, or commits any other fraud under or with respect to, the Plan, the Administrator has the right to permanently terminate coverage for the individual and their Dependents to the extent permitted by law. This may include, but is not limited to, submitting falsified claims or obtaining coverage for an individual who is ineligible (for example, adding a spouse before the date of marriage or failing to notify the Plan of a divorce from a covered spouse). Any termination of coverage will be effective on the date determined by the Administrator. Notwithstanding the foregoing: (a) any termination of medical coverage will generally be effective on a prospective basis; provided, however, that, in the case of fraud or an intentional misrepresentation of material fact, the individual's coverage may be terminated by the Administrator on a retroactive basis (a "Rescission" of coverage), in which case the individual will receive a notice of the Rescission (as an "adverse benefit determination"), as required by the Affordable Care Act; and (b) with respect to disability coverage, to the extent coverage is Rescinded by the Administrator, the individual will receive a notice of the Rescission (as an "adverse benefit determination"), as required by ERISA. To the extent permitted by law, the Administrator may also seek reimbursement from the individual for all claims or expenses paid by the Plan as a result of the false representation or other fraud, and may pursue legal action against the individual.

ARTICLE XIII
ADMINISTRATION

Section 13.01 Administration. The principal duty of the Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive purposes of providing benefits to the Participants and their beneficiaries and defraying reasonable administrative expenses of the Plan, and operated consistently for similarly situated individuals. Except as provided in Section 14.01(b), the Administrator will be the "named fiduciary" of the Plan, within the meaning of Section 402(a) of ERISA for all Benefit Programs that are subject to ERISA.

Section 13.02 Liability and Indemnification. Each person who is a named fiduciary or a member of any committee or board comprising a named fiduciary shall be indemnified by the Company against costs, expenses and liabilities (other than amounts paid in settlement to which the Company does not consent) reasonably incurred by them in connection with any action to which they may be a party by reason of their service as a named fiduciary except in relation to matters as to which they shall be adjudged in such action to be personally guilty of gross negligence or willful misconduct in the performance of their duties. The foregoing right to indemnification shall be in addition to such other rights as the person may enjoy as a matter of law or by reason of insurance coverage of any kind, but shall not extend to costs, expenses and/or liabilities otherwise covered by insurance or that would be so covered by any insurance then in force if such insurance contained a waiver of subrogation. Rights granted hereunder shall be in addition to and not in lieu of any rights to indemnification to which the person may be entitled pursuant to the bylaws of the Company. Service as a named fiduciary shall be deemed in partial fulfillment of the person's function as an employee, officer, or director of the Company, if the person serves in that capacity as well as in the role of named fiduciary. A Plan fiduciary that is a third party service provider or an Insurance Company will be entitled to indemnification only to the extent provided in a written agreement with such service provider.

Section 13.03 Powers and Authority of Administrator. The Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Administrator's powers will include, but will not be limited to, unilateral discretion to do the following, in addition to any other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including (i) the establishment of claims review procedures in accordance with Section 503 of ERISA or other applicable law and regulations, (ii) the establishment of QMCSO procedures in accordance with Section 609 of ERISA, and (iii) rules and regulations for the conduct of business by the Administrator;

(b) To interpret the Plan and to determine all questions arising under or in connection with the Plan, including all questions of eligibility to participate and obtain benefits under the Plan, its interpretation thereof in good faith to be final and conclusive on all interested persons. The Administrator has sole discretionary authority to grant or deny benefits under this Plan. Benefits under this Plan will be paid only if the Administrator decides, in its discretion, that the Participant is entitled to them; provided, however, that the Administrator may delegate to an Insurance Company or Claims Administrator, in accordance with Article XIII, the right and discretion to make determinations as to claims;

(c) To appoint such agents, counsel, accountants, consultants and other persons (regardless of whether they also provide services to the Company) as may be required to assist in administering the Plan;

(d) To allocate and delegate its responsibilities under the Plan and to designate other persons from time to time to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing;

(e) To request of and obtain from any Employee, Employer or the Company such information and records as it deems necessary and proper;

(f) To develop enrollment and any other forms necessary for Plan administration; and

(g) To delegate the duty of claims decisions and adjudication to an Insurance Company or third party administrator. Such Insurance Company or third party administrator will be the Claims Administrator or Claims Fiduciary under this Plan.

All actions and determinations of the Administrator will be final and binding upon all Employees, Participants, Dependents, beneficiaries, Employers, the Company and any other interested parties.

Section 13.04 Records and Reports. The Administrator will maintain such records of its activities and of Participants and operations as it deems necessary and appropriate. Plan records pertaining to the Company, the Employers or Employees (subject to any privacy and confidentiality protections required by law or established by the Administrator's rules) will be available for examination by the Company at reasonable times during normal business hours. The Administrator's Plan records pertaining to a Participant will be available for examination by such Participant upon written request at reasonable times during normal business hours.

To the extent required by applicable law, the Administrator will provide each eligible Employee from time to time with a written explanation of the Plan in form and substance sufficient to satisfy the summary plan description requirements of 29 C.F.R. §§ 2520.102-2 through 2520.102-4. Upon written request, the Administrator will furnish a Participant (or beneficiary) with a copy of the latest updated summary plan description, the latest annual report, any trust agreement, contract, or other instrument under which the Plan is established or operated, within 30 days of the request.

The Administrator will make such reports to the Company as it will reasonably request, and such reports to government authorities as applicable law will require.

ARTICLE XIV
CLAIMS ADMINISTRATION

Section 14.01 General. All claims for benefits under the Plan will be submitted in writing to and decided by such persons or organizations as the Administrator may from time to time designate, in the form and within the time specified by the Administrator. The Administrator may delegate its authority and responsibilities under this Article to a Claims Administrator, provided such delegation is in writing. Any reference to Administrator in this Article will mean the applicable Claims Administrator if the relevant authority and responsibility has been delegated by the Administrator to that Claims Administrator and in the case of insured arrangements, shall mean the Insurance Company. The Administrator has sole discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan will be paid only if the Administrator decides in its sole discretion that the Claimant is entitled to them. The Administrator's decisions made pursuant to this Article are intended to be final and binding on Participants, beneficiaries and others.

(a) Applicable Procedures. For all Health Care Claims, the expedited claims procedures set forth in Section 14.03 will apply. For disability claims, the claims procedures set forth in Section 14.04 will apply. For all other claims filed under the Plan, the claims procedures set forth in Section 14.05 will apply. Notwithstanding the foregoing, to the extent that the Administrator properly delegates its claims authority to a Claims Administrator, the Claims Administrator may apply alternative time frames than that set forth in this Article. In such circumstance, such alternative time frames will control. In any case, each claims procedure set forth in this Article or applied by the Claims Administrator is intended to comply with 29 C.F.R. § 2560.503-1 and, as applicable, the Affordable Care Act (e.g., at 29 C.F.R. § 2590.715-2719), the Consolidated Appropriations Act, and any other applicable law, the applicable provisions of which are hereby incorporated into the Plan by reference.

(b) Insured Programs. Notwithstanding any provision of this Plan to the contrary, to the extent that an Insurance Company (or other Claims Administrator) administers claims under a Benefit Program, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such Insurance Company or Claims Administrator. The Insurance Company will determine claims related to eligibility only to the extent eligibility depends on an insurance requirement, such as evidence of insurability. In such cases, the Insurance Company or other Claims Administrator will have discretionary authority to decide such claims under this Section 14.01 and will be the "named fiduciary" for purposes of such Benefit Program, as permitted under 29 C.F.R. § 2560.503-1(g).

(c) Authorized Representatives. A Claimant may designate an authorized representative to act on Claimant's behalf in pursuing a benefit claim or appeal of an adverse benefit determination. The Claimant may specify the purposes for which the authorized representative may act on its behalf. In order to designate an authorized representative, a Claimant must complete all forms required by the Administrator and follow all procedures established by the Administrator. Upon receipt and approval of all necessary forms, the Administrator will direct all information and notification to which the Claimant is otherwise entitled with respect to the aspect of the claim or appeal specified by the Claimant.

Section 14.02 Processing of Claims. Unless a Program Document provides for a shorter period, all claims must be submitted within one year after the date the claim accrues. The Administrator will process a claim promptly after it receives complete written proof of the claim. The Administrator may process an Urgent Care Claim without a complete written proof of claim, provided that any benefit paid is conditioned upon the Administrator receiving a complete written proof of claim within a reasonable period of time thereafter. If the Administrator finds that benefits are payable under the Plan, it will send payment to the Claimant, unless such individual authorizes payment to be made directly to the provider of services or supplies.

Section 14.03 Health Care Claims.

(a) Definitions. For purposes of this Section, the following terms as each is defined in Article II will apply: (i) Concurrent Care Claim, (ii) Health Care Claim, (iii) Post-Service Claim, (iv) Pre-Service Claim, and (v) Urgent Care Claim; and each shall be interpreted in accordance with the applicable provisions of ERISA, the Affordable Care Act, and any other applicable law.

(b) Time Limits for Initial Claims. Any person who believes that they are then entitled to receive a health care benefit under the Plan, including one greater than that initially determined by the Administrator, may file a Health Care Claim in writing with the Administrator. The Administrator will notify a Claimant of its benefits determination, depending on the type of claim, within a specific time period, as set forth in this subsection.

(i) Urgent Care Claim: The Administrator will provide notice of the Plan's benefit determination to a Claimant as soon as possible, but no later than 72 hours after the Plan receives an Urgent Care Claim. However, if the Claimant does not follow the Plan's claims procedure or does not provide sufficient information with a claim, the Administrator will notify the Claimant of the deficiency as soon as possible, but not later than 24 hours after receiving the claim. Such notice will describe the proper claims procedure and/or the specific information necessary to complete the Urgent Care Claim. If an Urgent Care Claim is incomplete or the Administrator requires more information, a Claimant will have at least 48 hours to provide the specified information. In the case of an incomplete initial claim, the Administrator will notify a Claimant of its benefits determination no later than 48 hours after the earlier of:

(A) the time the Administrator receives the specified information; or

(B) the end of the period in which a Claimant was allowed to provide the required information.

(ii) Pre-Service Claim (Not Involving An Urgent Care Claim): The Administrator will notify a Claimant of a Plan's benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Administrator receives a Pre-Service Claim (or such shorter period applicable in the event a second level of appeal is available). The Administrator may extend this 15-day period one

time for up to 15 days, if the Administrator determines that more time is necessary due to matters beyond the Plan's control. The Administrator will notify a Claimant before the end of the initial 15-day period if an extension is necessary. If the extension is necessary because a Claimant did not submit required information, the Administrator will, in the notice, specifically describe the required information and will provide the Claimant with an additional 45 days to provide the information. In this case, the time period allowed for making the benefits determination is tolled from the date the notice is sent to the Claimant until the date the Claimant responds to the notice. If the Claimant does not follow the Plan's claims procedure, the Administrator will notify the Claimant as soon as possible, but not later than five calendar days after receiving the Pre-Service Claim. The notice will describe the proper procedure for filing the Pre-Service Claim.

(iii) Concurrent Care Claim: For a Concurrent Care Claim relating to Urgent Care, the Administrator will notify a Claimant as soon as possible, taking into account the medical exigencies, but generally no longer than 24 hours, provided that any such claim is made to the Plan at least 24 hours before the prescribed period of time or number of treatments expires. For a Concurrent Care Claim relating to non-Urgent Care, the Administrator will notify a Claimant sufficiently in advance of the reduction or termination of the Claimant's treatment to allow a Claimant to appeal and obtain a review of the Concurrent Care Claim before the treatment is reduced or terminated.

(iv) Post-Service Claim: The Administrator will notify a Claimant of a Plan's benefit determination not later than 30 days after the Administrator receives a Post-Service Claim (or such shorter period applicable in the event a second level of appeal is available). If the Administrator determines that more time is necessary due to matters beyond the Plan's control, the Administrator may extend this 30-day period one time, for up to 15 days. The Administrator will notify a Claimant before the end of the initial 30-day period if an extension is necessary. If the extension is necessary because a Claimant did not submit required information, the Administrator will specifically describe the required information and will provide a Claimant with an additional 45 days to provide the information. In this case, the time period allowed for making the benefits determination is tolled from the date the notice is sent to a Claimant until the date the Claimant responds to the notice.

(c) Notice of Initial Denial. The Administrator's denial of a claim will be written in a manner calculated to be understood by the Claimant and will include:

(i) the specific reason or reasons for the benefit determination;

(ii) information sufficient to specifically identify the claim involved (including denial codes);

(iii) references to specific Plan provisions on which the benefit determination is based;

(iv) a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(v) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information Relevant to the Claimant's claim;

(vi) an explanation of the appeal procedure;

(vii) if an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such document was relied upon and that a copy will be furnished (free of charge) upon request;

(viii) if the decision was 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 Plan's terms to the Claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;

(ix) a statement disclosing the availability of, and contact information for, any applicable consumer assistance office or ombudsman established to assist individuals with claims and appeals questions; and

(x) a statement that the Claimant has the right to bring civil action under Section 502(a) of ERISA following a denial upon appeal.

(d) Claimant's Right to Appeal. A Claimant (or their duly authorized representative) whose claim is denied in whole or in part by the Administrator may, within 180 days after receipt of denial of their claim or, if no notice of denial was received, within 180 days of the date the notice should have been provided:

(i) submit a written request for review by the Administrator;

(ii) receive reasonable access to, copies (free of charge) of all documents, records and other information Relevant to the Claimant's claim; and

(iii) submit written comments, documents, records and other information relating to the claim for benefits.

(e) Independent Review. The review of the initial decision concerning a Claimant's claim must be performed by someone who is neither the original decision maker nor the subordinate of the original decision maker. In reviewing the initial decision, the decision maker must not give any deference to the initial decision and must consider all information Relevant to

the claim, not just information relied upon (or available) when the original decision was made. The decision maker must also consider any information submitted by the Claimant.

If the benefit determination is based in whole or in part on a medical judgment, the decision maker reviewing the claim will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment issue; provided that such health care professional will be an individual who is neither an individual who was consulted in the connection with the initial claim denial that is the subject of the appeal nor the subordinate of any such individual. The Plan will disclose to the Claimant the identity of medical or vocational experts whose advice was obtained by the Plan in connection with the review, even if the advice was not relied upon in making the final decision.

The decision maker will also provide the Claimant, free of charge, any new or additional evidence considered, relied upon, or generated in connection with the Claimant's appeal. In addition, before the Claimant receives an adverse benefit determination on review based on a new or additional rationale, the decision maker will provide the Claimant, free of charge, with the rationale.

(f) Time Limits for Decision on Appeal. The Administrator will furnish the Claimant with a written decision providing the final decision concerning the claim as soon as practicable from the date of the request for appeal was submitted, but not later than:

(i) 72 hours after receipt of the Claimant's request for review of an Urgent Care Claim benefit determination;

(ii) 30 days (or 15 days in the event the Administrator offers two levels of appeal) after receipt by the Plan of the Claimant's request for review of a Pre-Service Claim benefit determination; or

(iii) 60 days (or 30 days in the event the Administrator offers two levels of appeal) after the receipt by the Plan of the Claimant's request for review of a Post-Service Claim benefit determination.

(g) Notice of Decision on Appeal. The final decision concerning an appeal of a claim will be written in a manner calculated to be understood by the Claimant and will include:

(i) the specific reason or reasons for the benefit determination;

(ii) information sufficient to specifically identify the claim involved (including denial codes);

(iii) references to specific Plan provisions on which the benefit determination is based;

(iv) 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;

(v) an explanation of any voluntary appeal procedures offered by the Plan, if any;

(vi) if an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such document was relied upon and that a copy will be furnished (free of charge) upon request;

(vii) if the decision was 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 Plan's terms to the Claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;

(viii) a statement disclosing the availability of, and contact information for, any applicable consumer assistance office or ombudsman established to assist individuals with claims and appeals questions;

(ix) a statement regarding the availability of external review; and

(x) a statement that the Claimant has the right to bring civil action under Section 502(a) of ERISA following a denial upon appeal.

(h) Notwithstanding the foregoing, Claimants may not seek benefits under the Plan in judicial or administrative proceedings without first complying with and fully exhausting the procedures set forth in this Section 14.03. In addition, Claimants must bring civil action under Section 502(a) of ERISA within two years after the Claimant's initial claim or within six months from the date of the final claim decision on appeal, whichever comes first, or if shorter, the date specified in the Benefit Program. The decisions made pursuant to this Section 14.03 will be final and binding on Claimants and any other party.

(i) External Review. A Claimant may be eligible for independent external review pursuant to federal law after exhausting the internal appeal process.

(i) Eligibility for External Review. In accordance with (and to the extent required by) ERISA (e.g., at 29 C.F.R. § 2590.715-2719(d)(1)), external review is only available with respect to adverse benefit determinations involving:

(A) medical judgment (except claims that only involve interpretation of a contract or law without any use of medical judgment);

(B) consideration of whether the Plan (or the Insurance Company) is complying with the surprise billing and cost-sharing protections required by the Consolidated Appropriations Act (as set forth in Sections 716 and 717 of ERISA); or

(C) a Rescission of coverage, regardless of whether the Rescission has any effect on any particular benefit at that time.

(ii) Request for Review. A Claimant must file a request for external review within four months after the date the Claimant receives notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(iii) Preliminary Review. Within five business days after receiving a Claimant's request for external review, the decision maker will complete a preliminary review of the request to determine:

(A) Whether the Claimant is or was covered under the Benefit Program at the time the health care item or service was requested or provided;

(B) Whether the Claimant was eligible to participate in the Benefit Program and if the adverse benefit determination was related to that;

(C) Whether the Claimant exhausted the Benefit Program's internal appeal process or if the Claimant was deemed to have exhausted the internal appeals process; and

(D) Whether the Claimant provided all the information and forms required to process an external review.

The decision maker will notify Claimants in writing of its findings within one business day after completing this preliminary review. If a Claimant's request is complete but not eligible for external review, the Claimant will be notified of the reasons for its ineligibility and will be given contact information for the Employee Benefits Security Administration. If the Claimant's request is not complete, the Claimant will be informed of the information or materials needed to make the request complete. The Claimant will have not less than 48 hours or the remaining time in the four month filing period to provide this information - whichever is longer.

(iv) Referral to Independent Review Organization. The Benefit Program will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. The IRO will determine if the adverse benefit determination involves medical judgment.

(v) Request for Expedited External Review. For Pre-Service Claims involving urgent/concurrent care, a Claimant may proceed with an expedited external

review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Plan's internal appeal process.

Section 14.04 Disability Claims.

(a) Time Limits for Initial Claims. Any person who believes that they are then entitled to receive a disability benefit under the Plan, including one greater than that initially determined by the Administrator, may file a claim in writing with the Administrator. The Administrator (or the Administrator's designee) will, within 45 days of the receipt of a claim, either grant or deny the claim in writing. An extension of 30 days will be allowed for processing the claim if necessary due to matters beyond the Plan's control and the Claimant receives notice of such extension before the expiration of the initial 45-day period. The notice will state the special circumstances involved and the date a decision is expected. If, before the end of the first 30-day extension period, the Administrator 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 the Administrator notifies the Claimant before the expiration of the first 30-day extension period of the circumstances requiring the additional extension and the date as of which the Plan expects to render a decision. In the case of any extension under this subsection (a), the notice of extension will specifically explain the standards on which the 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 additional information. If additional information is requested to resolve the issues, the time period allowed for making the benefits determination is tolled from the date the notice is sent to a Claimant until the date the Claimant responds to the notice.

(b) Notice of Initial Denial. The Administrator's denial of a claim will be written in a culturally and linguistically appropriate manner, calculated to be understood by the Claimant and will include:

(i) the specific reason or reasons for the benefit determination;

(ii) references to specific Plan provisions on which the benefit determination is based;

(iii) a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) a 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;

(v) an explanation of the appeal procedure;

(vi) if an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such

document was relied upon and that a copy will be furnished (free of charge) upon request;

(vii) if the decision was 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 Plan's terms to the Claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;

(viii) a discussion of the decision including an explanation of the basis for disagreeing with or not following: (i) the views presented to the Plan of health care professionals treating the Claimant or vocational professionals who evaluated the Claimant; (ii) the views of the 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 (iii) a Social Security Administration disability determination presented by the Claimant to the Plan; and

(ix) a statement that the Claimant has the right to bring civil action under Section 502(a) of ERISA following a denial upon appeal.

(c) Claimant's Right to Appeal. A Claimant (or the Claimant's duly authorized representative) whose claim is denied in whole or in part by the Administrator may, within 180 days after receipt of denial of their claim or, if no notice of denial was received, within 180 days of the date the notice should have been provided:

(i) submit a written request for review by the Administrator;

(ii) receive reasonable access to, copies (free of charge) of all documents, records and other information Relevant to the Claimant's claim;

(iii) receive (free of charge) as soon as possible and sufficiently in advance of the date on which a notice of adverse benefit determine on review is required to be provided, any new or additional evidence considered, relied upon, or generated in connection with the Claimant's claim and any new or additional rationales forming the basis of the Plan's determination of the Claimant's claim; and

(iv) submit written comments, documents, records and other information relating to the claim for benefits.

(d) Independent Review. The review of the initial decision concerning a Claimant's claim must be performed by someone who is neither the original decision maker nor the subordinate of the original decision maker. In reviewing the initial decision, the decision maker must not give any deference to the initial decision and will consider all information Relevant to the claim, not just information relied upon (or available) when the original decision was made. The decision maker will also consider any information submitted by the Claimant.

If the benefit determination is based in whole or in part on a medical judgment, the decision maker reviewing the claim will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment issue; provided that such health care professional will be an individual who is neither an individual who was consulted in the connection with the initial claim denial that is the subject of the appeal nor the subordinate of any such individual. The Plan will disclose to the Claimant the identity of medical or vocational experts whose advice was obtained by the Plan in connection with the review, even if the advice was not relied upon in making the final decision.

(e) Time Limits for Decision on Appeal. The Administrator will furnish the Claimant with a written decision providing the final determination of the claim. The decision will be issued as soon as reasonable after the date the request for appeal was submitted, and usually within 45 days of the date in which the written appeal was submitted. The Administrator may take an additional 45 days to make this decision if special circumstances are present. The Administrator will give the Claimant notice if this extension is necessary before expiration of the initial 45-day period. In no event will such extension exceed a period of 45 days from the end of the initial 45-day period. 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.

(f) Notice of Decision on Appeal. The decision concerning an adverse decision on appeal will be written in a culturally and linguistically appropriate manner, calculated to be understood by the Claimant and will include:

(i) the specific reason or reasons for the benefit determination;

(ii) references to specific Plan provisions on which the benefit determination 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;

(iv) an explanation of any voluntary appeal procedures offered by the Plan, if any;

(v) if an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such document was relied upon and that a copy will be furnished (free of charge) upon request;

(vi) if the decision was 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 Plan's terms to the Claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;

(vii) a discussion of the decision including an explanation of the basis for disagreeing with or not following (i) the views presented to the Plan of

health care professionals treating the Claimant or vocational professionals who evaluated the Claimant; (ii) the views of the 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 (iii) a Social Security Administration disability determination presented by the Claimant to the Plan; and

(viii) a statement that the Claimant has the right to bring civil action under Section 502(a) of ERISA following a denial upon appeal and a description of any applicable Plan-imposed limitations period, including the calendar date when the limitations period will expire.

(g) Notwithstanding the foregoing, Claimants may not seek benefits under the Plan in judicial or administrative proceedings without first complying with and fully exhausting the procedures set forth in this Section 14.04. In addition, Claimants must bring civil action under Section 502(a) of ERISA within two years after the Claimant's initial claim or within six months from the date of the final claim decision on appeal, whichever comes first, or if shorter, the date specified in the Benefit Program. The decisions made pursuant to this Section 14.04 are final and binding on Claimants and any other party.

Section 14.05 All Other Claims.

(a) Time Limits for Initial Claims. Any person who believes that they are then entitled to receive a benefit under the Plan, including one greater than that initially determined by the Administrator, may file a claim in writing with the Administrator. The Administrator (or the Administrator's designee) will, within 90 days of the receipt of a claim, either grant or deny the claim in writing. An extension of 90 days will be allowed for processing the claim if special circumstances are involved and the Claimant is notified of such extension before the expiration of the initial 90-day period. The notice will state the special circumstances involved and the date a decision is expected. If no notice is received during that period, the claim will be deemed denied and the Claimant may request a review of the decision.

(b) Notice of Initial Denial. The Administrator's denial of a claim will be written in a manner calculated to be understood by the Claimant and will include:

(i) the specific reason or reasons for the benefit determination;

(ii) references to specific pertinent Plan provisions on which the benefit determination is based;

(iii) a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) a 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;

(v) an explanation of the appeal procedure; and

(vi) a statement that the Claimant has the right to bring civil action under Section 502(a) of ERISA following a denial upon appeal.

Notwithstanding the foregoing, if the Administrator does not timely respond to a claim in writing, the claim will be deemed denied.

(c) Claimant's Right to Appeal. A Claimant (or the Claimant's duly authorized representative) whose claim is denied in whole or in part by the Administrator may, within 60 days after receipt of denial of their claim:

(i) submit a written request for review by the Administrator;

(ii) receive reasonable access to, copies (free of charge) of all documents, records and other information Relevant to the Claimant's claim; and

(iii) submit written comments, documents, records and other information relating to the claim for benefits.

(d) Time Limits for Appeal. The Administrator will furnish the Claimant with a written decision providing the final determination of the claim. The decision will be issued as soon as reasonable after the date the request for appeal was submitted, and usually within 60 days of the date in which the written appeal was submitted. The Administrator may take an additional 60 days to make this decision if special circumstances are present. The Administrator will give the Claimant notice if this extension is necessary before termination of the initial 60-day period. The notice will state the special circumstances involved and the date a decision is expected. In no event will such extension exceed a period of 60 days from the end of the initial 60-day period.

(e) Notice of Appeal. The decision concerning an appeal of a claim will be written in a manner calculated to be understood by the Claimant and will include:

(i) the specific reason or reasons for the denial;

(ii) references to specific Plan provisions on which the benefit determination 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;

(iv) an explanation of the voluntary appeal procedures offered by the Plan, if any; and

(v) a statement that the Claimant has the right to bring civil action under Section 502(a) of ERISA following a denial upon appeal.

Section 14.06 Exhaustion of Administrative Remedies. Claimants will not be entitled to challenge the Administrator's determinations in judicial or administrative proceedings without first complying with the administrative claims procedures set forth in the applicable Program Document or under this Article, as appropriate. All such claims must be brought within the timeframes set forth above for the Claimant's type of claim. The decisions made pursuant to applicable administrative claims procedures are final and binding on the Claimant and any other party. A Claimant may, however, seek an external review if their claim meets the conditions set forth in this Article. If the Claimant has complied with and exhausted the appropriate claims procedures and intends to exercise his right to bring civil action under ERISA Section 502(a), the Claimant must bring civil action under ERISA Section 502(a) within one year after the Claimant's initial claim or within six months from the date of the final claim decision on appeal, whichever comes first, or if shorter, the date specified in the Benefit Program. If the Claimant does not bring such action within such period, the Claimant will be barred from bringing an action under ERISA related to their claim.

Section 14.07 Forum Selection. Any legal action (whether in law, in equity or otherwise) must be brought in the in the forum set forth in Section 18.07.

Section 14.08 Incompetency. If any person entitled to payments under the Benefit Programs is a minor or under other legal disability or otherwise incapacitated so as to be unable to manage their financial affairs, or is otherwise incapable of giving a valid receipt and discharge for any payment, the following provision will apply. If the payment is to be made by an Insurance Company, such payment will be made in accordance with the terms of the contract under which such benefit is payable. If the payment is to be otherwise made, the Administrator, in its discretion, may direct that all or any portion of such payment be made:

(a) to such person;

(b) to such person's legal guardian or conservator; or

(c) to such person's Spouse or to any other person; and

in any manner the Administrator considers advisable, to be expended for their benefit. The decision of the Administrator (or, where applicable, that of the Insurance Company) will, in each case, be final and binding upon all persons. Any payment made pursuant to the power herein conferred will operate as a complete discharge of the obligations of the Benefit Programs, the Company, the Employers, the Administrator, and any Insurance Company, with respect to such payment.

ARTICLE XV
AMENDMENT AND TERMINATION

Section 15.01 Amendment. The Company reserves the discretionary right to modify or amend the Plan, including any Appendix hereto, in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by the Board of Directors, and duly executed on behalf of the Company or such designee. Such amendment shall be binding on any Employers without further action. However, no Plan amendment will be valid which would cause the Plan to fail any applicable qualification requirements of the Code, so long as such requirements apply to this Plan. The Administrator will have the right to amend any provision of the Plan that is administrative, procedural, or ministerial in nature, and any written policy, rule, procedure or similar action adopted by the Administrator that is inconsistent with any administrative, procedure or ministerial provision of the Plan will be deemed an amendment.

Section 15.02 Termination of the Plan. The Company reserves the right to terminate the Plan or any Benefit Program at any time as designated by a written instrument adopted by the Board of Directors or its designee and duly executed on behalf of the Company. Upon termination of the Plan, the Company will direct the Administrator to either restore any unused Account balances to the Compensation of each respective Participant or to continue to apply such balances towards Participants' benefits in accordance with Articles VII and VIII for the remainder of the Plan Year, subject to forfeiture thereafter.

ARTICLE XVI
PARTICIPATING EMPLOYERS

Section 16.01 Adoption of Plan. An Affiliate may become an Employer and commence participating in the Plan, subject to the provisions of this Article XVI. For an Affiliate to become an Employer, the Company must approve the Affiliate's adoption of the Plan as an Employer and specify the date of such adoption. The name of any Affiliate that commences participation in the Plan, along with the effective date of its participation, may be recorded by resolution of the Company and included on Appendix B, which Appendices may be appropriately modified from time to time by the Administrator or its delegate to reflect any change in the current Employers. Unless the Company determines otherwise, an Employer shall automatically cease to be an Employer upon the cessation of its status as an Affiliate.

Section 16.02 Administration. As a condition to adopting the Plan, and except as otherwise provided herein, each Employer will be deemed to have authorized the Company and the Administrator of the Plan to act for it in all matters arising under or with respect to the Plan and will comply with such other terms and conditions as may be imposed by the Company and the Administrator.

Section 16.03 Company as Agent for Employers. Each Affiliate that becomes an Employer, by doing so, appoints the Company as its agent to exercise on its behalf all of the powers and authorities conferred upon the Company by the terms of the Plan, including, but not limited to, the power to amend and terminate the Plan. The authority of the Company to act as such agent will continue unless and until the Employer terminates participation in the Plan pursuant to Section 16.04.

Section 16.04 Termination. The Company may terminate the designation of an Affiliate as an Employer, or any Benefit Program with respect to an Employer, effective as of any date. Each Employer, other than the Company, may cease to participate in the Plan or in any Benefit Program with respect to its Participants with the approval of the Company, by action of its board of directors (or other governing body) or its authorized delegate. The withdrawal of an Employer shall be effective as of the last day of the Plan Year in which the withdrawal occurs, unless the Company consents to a different effective date.

ARTICLE XVII
HIPAA PRIVACY AND SECURITY

Section 17.01 General. The Plan is a "hybrid entity" as defined under 45 C.F.R. § 164.103 (i.e., a covered entity whose business activities include both covered and non-covered functions under HIPAA), and hereby it is designated the portion(s) of the Plan that constitute Health Care Component(s) in accordance with 45 C.F.R. § 164.105(a)(2)(iii)(C). The Health Care Component(s) of the Plan are subject to this Article and will comply with the standards for privacy of individually identifiable health information as set forth in the Privacy Rule and the security standards for the protection of Electronic PHI as set forth in the Security Rule.

Section 17.02 Responsible Employees. Only Responsible Employees (as defined below in this section) will be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or EPHI on behalf of a HIPAA Health Plan. The use or disclosure of PHI or EPHI by Responsible Employees will be restricted to the HIPAA Health Plan administration functions that the Company performs on behalf of a HIPAA Health Plan, pursuant to Section 17.03.

(a) Company employees who perform the following functions on behalf of the HIPAA Health Plans are Responsible Employees:

(i) claims determination and processing functions;

(ii) HIPAA Health Plan vendor relations functions;

(iii) benefits education and information functions;

(iv) HIPAA Health Plan administration activities;

(v) legal department activities;

(vi) HIPAA Health Plan compliance activities;

(vii) information systems and HRIS support activities;

(viii) payroll and finance activities;

(ix) internal audit functions; and

(x) human resources functions.

(b) In addition to those individuals described in subsection (a) above, the Administrator who performs claims appeals and other decision-making functions on behalf of the HIPAA Health Plans, the HIPAA Health Plans' HIPAA Privacy and Security Official, and Company employees to whom the HIPAA Health Plans' HIPAA Privacy and Security Official has delegated any of the following responsibilities will also be Responsible Employees:

(i) implementation, interpretation, and amendment of the Privacy Policy;

(ii) Privacy Rule training for Company employees;

(iii) investigation of and response to complaints by Covered Persons and/or employees;

(iv) preparation and maintenance of the privacy notice for the Health Care Component(s);

(v) distribution of the privacy notice;

(vi) response to requests by Covered Persons to inspect or copy PHI;

(vii) response to requests by Covered Persons to restrict the use or disclosure of their PHI;

(viii) response to requests by Covered Persons to receive communications of their PHI by alternate means or in an alternate manner;

(ix) amendment and response to requests to amend Covered Persons' PHI;

(x) response to requests by Covered Persons for an accounting of disclosures of their PHI;

(xi) response to requests for information by the Department of Health and Human Services;

(xii) approval of disclosures to law enforcement or to the military for government purposes;

(xiii) maintenance of records and other documentation required by the Privacy Rule or the Security Rule;

(xiv) negotiation of Privacy Rule and Security Rule provisions and/or reasonable security provisions into contracts with third party service providers;

(xv) maintenance of Health Plan PHI security documentation; or

(xvi) approval of access to EPHI.

Section 17.03 Permitted Uses and Disclosures. Responsible Employees may access, request, receive, use, disclose, create, and/or transmit PHI only to perform certain permitted and required functions on behalf of Health Care Component(s), consistent with the Privacy Policy. This includes:

(a) uses and disclosures for the Health Care Component(s)' own Payment and Health Care Operations functions;

(b) uses and disclosures for another HIPAA Health Plan's Payment and Health Care Operations functions;

(c) disclosures to a health care provider, as defined under 45 C.F.R. § 160.103, for the health care provider's treatment activities;

(d) disclosures to the Company, acting in its role as Plan sponsor, of (i) summary health information for purposes of obtaining health insurance coverage or premium bids for the Health Care Component(s) or for making decisions to modify, amend, or terminate the Health Care Component(s); or (ii) enrollment or disenrollment information;

(e) disclosures of a Covered Person's PHI to the Covered Person or their personal representative, as defined under 45 C.F.R. § 164.502(g);

(f) disclosures to a HIPAA Health Plan for the other HIPAA Health Plan's Payment or Health Care Operations activities;

(g) disclosures to a Covered Person's family members or friends involved in the Covered Person's health care or payment for the Covered Person's health care, or to notify a Covered Person's family in the event of an emergency or disaster relief situation;

(h) uses and disclosures to comply with workers' compensation laws;

(i) uses and disclosures for legal and law enforcement purposes, such as to comply with a court order;

(j) disclosures to the Secretary of Health and Human Services to demonstrate the compliance of the Health Care Component(s) with the Privacy Rule;

(k) uses and disclosures for other governmental purposes, such as for national security purposes;

(l) uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;

(m) uses and disclosures to identify a decedent or cause of death, or for tissue donation purposes;

(n) uses and disclosures required by other applicable laws; and

(o) uses and disclosures pursuant to the Covered Person's authorization that satisfies the requirements of 45 C.F.R. § 164.508.

Notwithstanding anything in the Plan to the contrary, the use of Protected Health Information that is Genetic Information about an individual for underwriting purposes will not be a permitted use or disclosure.

Section 17.04 Certification Requirement. The Health Care Component(s) will disclose PHI and EPHI to Responsible Employees only upon receipt of a certification by the Company that the Company agrees:

(a) not to use or further disclose PHI other than as permitted or required by this Article and the Privacy Policy or as required by law;

(b) to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that the Company creates, receives, maintains or transmits on behalf of the Health Care Component(s);

(c) to take reasonable steps to ensure that any agents to whom the Company provides PHI or EPHI received from the Health Care Component(s) agree to:

(i) the same restrictions and conditions that apply to the Company with respect to such PHI;

(ii) implement reasonable and appropriate security measures to protect such EPHI.

(d) not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company other than another HIPAA Health Plan;

(e) to report to the Health Care Component(s) any use or disclosure of PHI that is inconsistent with the uses or disclosures described in Section 17.03 or any Security Incident of which the Company becomes aware;

(f) to make available PHI for inspection and copying in accordance with 45 C.F.R. § 164.524;

(g) to make available PHI for amendment, and to incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;

(h) to make available PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;

(i) to make its internal practices, books, and records relating to the use and disclosure of PHI received on behalf of the Health Care Component(s) available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Care Component(s) with the Privacy Rule;

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

(k) to take reasonable steps to ensure that there is adequate separation between the Health Care Component(s) and the Company's activities in its role as Plan sponsor and employer, and that such adequate separation is supported by reasonable and appropriate security measures.

Section 17.05 Mitigation. In the event of non-compliance with any of the provisions set forth in this Article,

(a) the HIPAA Privacy and Security Official will address any complaint promptly and confidentially. The HIPAA Privacy and Security Official first will investigate the complaint and document their investigation efforts and findings.

(b) if PHI has been used or disclosed in violation of the Privacy Policy or inconsistent with this Article, the HIPAA Privacy and Security Official will take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

(c) if a Responsible Employee or other Company employee is found to have violated the Privacy Policy, such personnel will be subject to disciplinary action up to and including termination.

ARTICLE XVIII
MISCELLANEOUS PROVISIONS

Section 18.01 Limitation of Rights. The establishment, maintenance and provision of the Plan will not be considered or construed: (i) as giving to any Employee any right to continue in the employment of any Employer; (ii) as limiting the right of any Employer to discipline or discharge any of its Employees; (iii) as creating any contract of employment between any Employer and any Employee; or (iv) as conferring any legal or equitable right against the Administrator, the Company, or the Employers.

Section 18.02 Rights to Employer Assets. Except as specifically provided in the Plan or in a Program Document, all balances reflect general assets of the Employers, and all payments made under this Plan are made from the general assets of the Employers. No Participant will have any right to or interest in any assets of the Company or any Employers, except as specifically provided in this Plan. The Administrator will have no liability to any Participant, the Company or any Employer for making any payment or providing any benefit pursuant to this Plan, and will merely direct such payments to be made by the Company (or an Employer) in accordance with the Plan.

Section 18.03 No Assignments. Unless specifically permitted by a Program Document, the right of any Participant to receive any benefits under the Plan (including the right to file a lawsuit against the Plan, any Program, the Company, any participating Employers, the Administrator, or any Plan fiduciary with respect to the Plan) will not be alienable by assignment. The right of any Participant to receive any benefits under the Plan will not be subject to any claims by any creditor of or claimant against the Participant; and any attempt to reach such amounts by any such creditor or claimant, or any attempt by the Participant to confer on any such creditor or claimant any right or interest with respect to such amounts, will be null and void, except as provided in Section 609 of ERISA with respect to QMCSO. The payment of Benefits may be made directly to a service provider who has provided medical care to a Participant or to any other third-party to whom such person is indebted as a convenience to such person, provided that such person shall remain primarily liable at all times with respect to payment for such medical care or other indebtedness and such payment shall not imply an enforceable assignment of benefits or the right to receive such benefits. No Compensation reduction elections or other contributions under this Plan will cause any Employer to be liable for, or subject to, any manner of debt or liability of any Participant.

Section 18.04 Severability. Any provision of the Plan will be severable, so that if any Plan provision is held invalid or unenforceable, such invalid or unenforceable provision will be severed from the Plan and the Plan will operate without regard to such severed provision. In such event, the Plan will be construed and enforced as if such severed provision had not been included herein, to the extent necessary to preserve the status of the Plan as qualified cafeteria plan under Section 125 of the Code.

Section 18.05 No Guarantee of Tax Consequences. The Company makes no commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludible from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any

Participant. Each Participant is obligated to determine whether each payment under this Plan is excludible from the Participant's gross income for federal and state income tax purposes, and to notify the Company if the Participant has reason to believe that any such payment is not so excludible.

Section 18.06 Unclaimed Benefits. Except as otherwise provided in a Program Document or the Plan, or as otherwise required by law, any benefit payment(s) remaining unclaimed (e.g., uncashed checks) for more than one year after issuance of the corresponding payment (e.g., issuance of check) or attempted payment will be forfeited and will be applied for any legally permissible purpose. With respect to the Health Care Spending Account(s), such forfeitures will be applied as described in Section 7.07. With respect to the Dependent Care Spending Account, such forfeitures will be applied as described in Section 8.07.

Section 18.07 Gender and Number. Except as otherwise clearly indicated by the context, whenever used in the Plan a pronoun in any gender will include any/all genders, words used in the singular will include the plural, and words used in the plural will include the singular, as circumstances make such meanings applicable.

Section 18.08 Governing Law and Forum Selection. The Plan will be construed in accordance with the laws of the State of California (determined without regard to any conflicts of law provisions), to the extent not preempted by federal law. Any legal action (whether in law, in equity or otherwise) must be brought in the U.S. District Court for the Central District of California, where the Plan is administered.

Section 18.09 Statutory and Regulatory References.

(a) Statutory References. Any general or specific reference herein to any statute or statutory provision(s) (e.g., of the Code, ERISA, etc.) will include any corresponding or succeeding provision(s) of any applicable legislation that amends, supplements, or replaces such provision(s), and for which compliance by or with respect to the Plan is required. Furthermore, any such reference shall include the regulations promulgated, and any other interpretive guidance issued, and effective thereunder and in effect with respect to the Plan.

(b) Regulatory References. Any general or specific reference herein to any section(s) of the Code of Federal Regulations ("C.F.R.") will mean the cited (or referenced) section(s) as in effect or as such may be amended from time to time, and for which compliance by or with respect to the Plan is required.

Section 18.10 Headings. All headings and captions used in this Plan are used as a matter of convenience and for reference only, and in no way will they be considered in determining the scope or intent of the Plan or in interpreting or construing any Plan provisions.

IN WITNESS WHEREOF, the Company has caused this duly adopted Plan to be executed below by its duly authorized officer or representative on this ____ day of _____, 2025 to be effective as of the Effective Date stated herein.

RIVIAN AND VW GROUP TECHNOLOGY, LLC

By:_____

Its:_____

APPENDIX A

The following Benefit Programs are consolidated into the Plan:

- Medical
- Prescription Drug
- Dental
- Vision
- Employee Assistance Program
- Wellness Program
- Short Term Disability*
- Short Term Disability
- Long Term Disability
- Life Insurance
- Accidental Death and Dismemberment
- Health Savings Account*
- Dependent Care Spending Account*
- Limited Health Care Spending Account
- Health Care Spending Account
- Health Reimbursement Account

* Indicates Benefit Programs that are not subject to ERISA.

APPENDIX B

The following entities are participating Employers:

Rivian and VW Group Technology, LLC