



SUMMARY PLAN DESCRIPTION

for the

CRETE CARRIER CORPORATION

FLEXIBLE BENEFITS PLAN,

DEPENDENT CARE ASSISTANCE PLAN

&

FLEXIBLE SPENDING ACCOUNT PLAN

Introduction

Crete Carrier Corporation (the “Employer”) has established the Crete Carrier Corporation Flexible Benefits Plan (the “Flexible Benefits Plan”) for its employees. The Employer also sponsors the Crete Carrier Corporation Dependent Care Assistance Plan and the Crete Carrier Corporation Flexible Spending Account Plan. This Summary refers to these three plans collectively as the “Plans.” Hunt Transportation, Inc. (the “Affiliate”) also participates in the Plans. The Employer may add other Affiliates from time to time. Even though you may be employed by an Affiliate, the Plans deem you to be employed by the Employer.

The Plans let you choose from several different insurance and fringe benefit programs according to your individual needs. The Employer provides you with the opportunity to use pre-tax dollars to pay for the benefits. You do not pay federal insurance contributions act (“FICA”) and income taxes on the amount of your salary reduction.

This Summary of the Plans explains their basic features effective January 1, 2026. It is only a Summary. If anything between this Summary is different than the actual terms of the Plans, the Plans control. Please contact the Crete Carrier Corporation Benefits Department at (800) 998-9100, if you have any questions.

1. General Information. The legal name, address, and Federal employer identification number of the Plan Sponsor are:

Crete Carrier Corporation
400 NW 56th Street
Lincoln, Nebraska 68528
EIN: 47-0496288

2. Identification of Plans; Plan Year. The names and Plan Numbers of the Plans are: Crete Carrier Corporation Flexible Benefits Plan (Plan No. 502); Crete Carrier Corporation Dependent Care Assistance Plan (Plan No. 503); Crete Carrier Corporation Flexible Spending Account Plan (Plan No. 501).

The Plans keep their records on a 12-month period from January 1 through December 31. The Plans refer to this period as the “Plan Year.”

3. Types of Plans. The Flexible Benefits Plan allows you to purchase benefits from the Benefit Plans on a pre-tax basis. The Employer may add or delete Benefit Plans at any time. Effective January 1, 2026, the Flexible Benefits Plan includes the following Benefit Plans:

Account Plans
Dependent Care Assistance Plan
Flexible Spending Account Plan

Group Health Plans
Group Health Care Plan
Group Dental Plan
Group Vision Plan

The Plan may also provide for payment of benefits that are not Group Health Plans or Account Plans, and refers to such plans as “Other Benefit Plans.” Currently, the Plan does not include any Other Benefit Plans.

4. Plan Administrator; Agent for Service of Process. Crete Carrier Corporation, the Plan Sponsor, is the Plan Administrator for the Plans. Its telephone number is (800) 998-9100.

The Plan Administrator provides information about your rights and benefits under the Plans. The Plan Administrator has full power to interpret and apply the terms of the Plans. The Plan Administrator also makes decisions regarding eligibility of individuals to participate and receive benefits from the Plans. It has the primary authority to file various reports, forms, and returns with the U.S. Department of Labor and Internal Revenue Service. The Employer may appoint a Committee to serve as Plan Administrator. If it does so, the Committee members may change from time to time. You may obtain a list of the current Committee members from the Employer.

The Plans must designate an agent for service of legal process. The agent for service of legal process is: General Counsel, Crete Carrier Corporation, 400 N.W. 56th St., Lincoln, NE 68528.

5. Funding. The Plans are funded through contributions from you and the Employer. The Employer determines how much it will contribute to the Plans on your behalf. You must make salary reductions to pay the remaining cost for the benefits provided by the Benefit Plans you select. The maximum amount you can contribute is the sum of your share of the cost for the highest cost Benefit Plans and the maximum contribution to Benefit Plans that are Account Plans. The Employer pays the entire cost of administering the Flexible Benefits Plan, Dependent Care Assistance Plan, and Flexible Spending Account Plan.

The Employer has written the rest of this Summary in a question and answer format. Section 6 contains information regarding the Flexible Benefits Plan. Section 7 contains information regarding the Dependent Care Assistance Plan. Section 8 contains information about the Flexible Spending Account Plan. If you have any additional questions, please contact the Plan Administrator.

6. Questions and Answers about the Flexible Benefits Plan.

The Flexible Benefits Plan (the “Plan”) allows eligible employees to use a portion of their compensation to pay for one or more of the benefits offered through the Plan on a tax-favorable basis. When you complete the Benefits Election, you specify which Benefit Plans you will pay for on a pre-tax basis. The Employer uses the amount taken from your compensation to pay your share of the cost of the coverage that you elect.

Who can participate in the Plan?

You are eligible to participate in the Plan if the Employer treats you as its employee, unless you are designated as a part-time employee, temporary employee, or contract employee. For purposes of the Plan, a “part-time employee” means an employee who regularly works less than 30 hours per week. The Employer treats you as an employee if it withholds taxes from your

compensation. If someone whom the Employer does not treat as its employee is later found to be its employee, the person participates in the Plan only from the date he or she is determined to be an employee. An employee designated as a temporary employee or contract employee is not eligible, no matter how many hours he or she works per week. Independent contractors (owner-operators), contractor's employees, leased employees, self-employed individuals, or 2 percent or more shareholders of an S Corporation are not eligible. However, independent contractors (owner operators) and their employees may be eligible to participate in the Benefit Plans (other than the Account Plans) on an after-tax basis.

When can an eligible employee begin to participate in the Plan?

An eligible employee may participate in the Plan on the first day of the month following the date on which he or she has been an eligible employee for 30 calendar days. If the employee's 30th day is the first day of the month, he or she can participate on that day. An eligible employee enters the Benefit Plans on the dates specified by those Plans.

How do I become a Participant?

The Employer will provide you with a Benefits Election when you first become employed or otherwise eligible to participate. It may provide you this election electronically or through a telephonic system. It may also use another method permitted by law. You become a Participant by completing the Benefits Election in the manner specified by the Plan Administrator. You must complete the Benefits Election on or before 31 days following the date you are eligible to participate in the Plan. The Plan Administrator may require supporting documentation (for example, proof of dependent status or marital status) in order to implement your Benefits Election. You must supply any such documentation before the deadline established by the Plan Administrator. The Benefits Election allows you to elect one or more of the benefits available under the Plan. It also contains a Salary Reduction Agreement so that the Employer may reduce your compensation to pay for the benefits you elect. For your first Plan Year of eligibility, the Benefits Election is effective for the rest of the Plan Year. If you elected benefits under any of the Benefit Plans, the Employer deems you to have elected to withhold enough of your salary to pay for your portion of the cost of those benefits. Otherwise, if you don't timely complete a Benefits Election, the Plan deems you to have elected to receive all of your compensation in cash.

Before the beginning of each following Plan Year, the Plan may have an "election period." The Employer does not guarantee to offer an election period for each Group Health Plan each Plan Year. During the election period, the Employer will let you complete a new Benefits Election. You can keep your election or make changes for the upcoming Plan Year based on your needs and availability of benefits. If you fail to timely complete a Benefits Election, the Plan deems you to have elected to receive the same election for the Group Health Plans as the previous year. It deems you to have elected to make \$0 in contributions to the Account Plans.

When do I stop being a Participant?

You are no longer a Participant in the Plan on the first to occur of the following:

- (a) The date you die or the last day of the month in which you terminate employment with the Employer (subject to continuation coverage rights discussed below);
- (b) The date you fail to make required contributions to the Plan;
- (c) The last day of the month in which you stop meeting the eligibility requirements; or
- (d) The date the Plan terminates.

Your coverage under the Benefit Plans will continue to the extent provided by those Plans.

What will happen to my previous Benefits Election if I am rehired by the Employer or again become an eligible employee?

If you terminate employment or otherwise cease to be an eligible employee and are rehired by the Employer or again become eligible within 90 days, you are not eligible to make a new election. You participate in the Plan under the terms of your Benefits Election in force prior to your termination or other loss of eligibility. You may make a new election during the next election period (discussed above) or if you have a Change in Status (discussed below).

If you are reemployed more than 90 days after you terminated employment, the Plan will treat you as a new participant. You will be allowed to complete a new Benefits Election.

If you ceased to be an eligible employee due to reasons other than termination of employment, and later become an eligible employee more than 90 days after you ceased to be an eligible employee, you may (a) elect to resume participation in the Plan under the terms of your Benefits Election in force prior to the loss of eligibility, subject to your right to complete a new Benefits Election during the election period or if you have a Change in Status, or (b) elect to be treated as a new eligible employee and be eligible to complete a new Benefits Election effective the first day of the month following the date you were again an eligible employee for 30 calendar days.

Can I change my Benefits Election during the Plan Year?

No, unless you have a Change in Status. A Change in Status for the Group Health Plans means one or more of the following events or circumstances occur:

- (a) Your marriage, divorce, legal separation, annulment, or death of a spouse.
- (b) An event that changes the number of your Dependents, including birth, adoption, placement for adoption of a child (as defined by the Internal Revenue Code (the “Code”)) or death.
- (c) You, your spouse, or your Dependent terminate or begin employment.

(d) You, your spouse, or your Dependent change from part-time to full-time employment status or vice versa. This includes a strike or lockout or commencement or return from an unpaid leave of absence.

(e) An event that causes your Dependent to satisfy or cease to satisfy the requirements for coverage of the Group Health Plans in which you participate. This includes age, student status, or any similar circumstances as provided in the Group Health Plans under which you receive coverage.

(f) Other events that change the employment status of you, your spouse, or your Dependent, if (i) the eligibility conditions for the cafeteria plan or other employee benefit plan of their employer depends upon employment status and (ii) there is a change in that employment status so that one or more of you becomes or ceases to be eligible under the plan.

(g) Your spouse or your Dependent experiences a change as defined by the flexible benefit plan of his or her employer. Their employer's plan must permit the election change according to applicable law or that plan must have a different plan year.

(h) The coverage under a Group Health Plan is significantly cut back resulting in a "complete loss of coverage." This will allow you to revoke your election and instead elect to receive coverage going forward under another benefit option providing similar coverage. If no similar benefit option is available under the Group Health Plans, you may revoke your election for coverage under the Plan. A "complete loss of coverage" includes a substantial decrease in the medical care providers available under a Group Health Plan. For example, if a major hospital ceases to be a member of the preferred provider network. It includes a reduction in the benefits for a specific type of medical condition or treatment that you, your spouse, or your Dependent currently receive. If coverage under a Group Health Plan is "significantly cut back" but it does not result in a complete loss of coverage, you may revoke your election. However, if available, you must instead elect to receive coverage going forward under another benefit option under the Group Health Plans. Coverage under the Group Health Care Plan is "significantly cut back" only if there is an overall reduction in coverage provided to employees under the Group Health Plan, so as to constitute reduced coverage to employees generally.

(i) The Employer adds a new benefit option or eliminates an existing benefit option. This allows you to elect the newly added option. It also allows you to elect another option if an option has been eliminated. However, your new election must correspond to a benefit option that provides similar coverage. You cannot change your election for unrelated benefits.

(j) There is a significant increase or decrease in the cost of a benefit option offered by the Employer during a period of coverage. If so, you may revoke your election and elect coverage under another benefit option under the Plan which provides similar coverage. For an increase, if no other benefit option under the Plan provides similar coverage, you may revoke your election for coverage under the Plan. For a decrease, you may elect to begin coverage in the Plan and elect the benefit option that has significantly decreased in cost if you were not already participating in the Plan.

(k) You are a party to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody related to accident or health coverage for your child or foster child. This allows the Employer to automatically change your election under the Group Health Plans to provide, cancel, or modify coverage as required by the judgment, decree, or order. Before the Employer will cancel coverage for a Dependent, you must demonstrate that another plan is actually providing coverage.

(l) You, your spouse, or your Dependent begins or ceases coverage under Medicare or Medicaid. This allows you to make an election change, cancel coverage, or elect new coverage for the affected individual under the Group Health Plans. For purposes of this Change in Status event, Medicare or Medicaid coverage does not include coverage consisting solely of benefits under the program for distribution of pediatric vaccines.

(m) You, your spouse, or your Dependent is no longer eligible for Medicaid under Title XIX of the Social Security Act or under any State Children's Health Insurance Program ("SCHIP") under Title XXI of the Social Security Act. This allows you to change your election to elect coverage under the Group Health Plans for you, your spouse, or your Dependent, so long as you request coverage under the Group Health Plans not later than 60 days after the date of termination of such coverage.

(n) You, your spouse, or your Dependent declined to enroll in the Plan and later become eligible for assistance through Medicaid or any SCHIP which provides help with paying for coverage under a Group Health Plan. This may allow you the right to enroll in the Plan and the Group Health Plans if you request coverage under the Plan not later than 60 days after the date the individual is determined to be eligible for such assistance.

(o) If you or your covered family member(s) are eligible to enroll for coverage in a qualified health plan through a government-sponsored Exchange (Marketplace) during a special enrollment period or annual open enrollment period, you may prospectively revoke your election for Group Health Care Plan coverage for you and your family members. However, you must certify that you certify that any individuals whose coverage is being revoked have enrolled or intend to enroll for new Exchange coverage that is effective beginning no later than the day immediately following the last day of the Group Health Care Plan coverage. The Plan Administrator will interpret this Change in Status event in accordance with guidance issued by the Department of Health and Human Services and other applicable guidance.

You may revoke an election for coverage under the Group Health Plans and make a new election that corresponds with the special election rights provided under HIPAA. This is true whether or not the change in election is one which would ordinarily permit an election change. These rights include the right to enroll new Dependents or existing Dependents that lose coverage or employer contributions to coverage under the health plan of another employer.

Section 7 explains the Change in Status rules for the Dependent Care Assistance Plan. Section 8 explains the Change in Status rules for the Flexible Spending Account Plan.

What other limits are there on my ability to change my election?

Your change in election must be because of and consistent with your Change in Status. The Change in Status must cause you, your spouse, or your Dependent to gain or lose eligibility for coverage under this Plan or other benefit plan of the Employer. Also, your election change must correspond to the gain or loss of coverage. Gaining or losing coverage means the individual becomes eligible or ineligible to participate in the Plan or a particular benefit option of the Plan. The following examples illustrate this consistency requirement:

Example 1 – You and your spouse divorce. As a result of the divorce, the court enters an order requiring your spouse to provide medical and dental coverage for your Dependents. You have two events that qualify as a Change in Status. The new election is consistent with your Change in Status if it eliminates coverage for your spouse, due to the divorce, and your Dependents, due to the court order. You may not revoke your coverage in this situation.

Example 2 – You have two children ages 7 and 12, and you pay expenses for the care of these children after school and in the summer. Your oldest child turns 13 and the Dependent Care Assistance Plan will no longer provide reimbursements for this child. You may revoke your Benefits Election and make a new election that considers the expenses of only the youngest child. You may not otherwise eliminate your election under the Dependent Care Assistance Plan in this situation.

Example 3 – You have two school-age children and a child who is age 25. Your 25 year old child turns 26 and no longer fits the definition of dependent under the Group Health Care Plan. He or she may no longer receive coverage. You may revoke an election for health coverage for the 26-year-old child. You may make a new election to cover only the two school-age children. You may not revoke your coverage or change the elections for the two school-aged children in this situation.

Example 4 – Your spouse dies. You may revoke your election under the Plan for health coverage for your spouse. You may not revoke or change your election for you or your Dependents in this situation.

When should I tell the Employer of my Change in Status?

You must inform the Employer of your new election as soon as possible, but no later than 31 days after the Change in Status occurs, except as otherwise provided. Your new election will be effective not earlier than the first pay period beginning after you complete a new Benefits Election in the manner specified by the Plan Administrator. The Plan Administrator may require supporting documentation (for example, proof of dependent status or marital status) in order to implement your Benefits Election. You must supply any such documentation before the deadline established by the Plan Administrator. Coverage under the Benefit Plans will take effect according to the terms of those Plans.

Can the Employer make other changes to my election?

The Employer may modify your election downward during the Plan Year if necessary to prevent the Plan from becoming discriminatory within the meaning of the Code. It will notify you if it takes this action.

What are the Benefit Plans available under the Plan?

The Employer sponsors several Benefit Plans identified in Section 3. The Plan allows you to pay your share of the premiums of the Benefit Plans on a pre-tax basis. The Benefits Election and Salary Reduction Agreement allow the Employer to reduce your compensation and use that amount to pay for the benefits. The reduction in your pay is only for purposes of this Plan. It does not affect other compensation-based plans or policies, such as the Employer's 401(k) Plan.

Who holds the funds I elect to contribute to the Benefit Plans?

Some Benefit Plans are funded using an insurance policy purchased from one or more insurance companies. The premiums for those Benefit Plans will be sent to that insurance company. Other Benefit Plans are funded through a self-insured arrangement sponsored by the Company. The premiums for those plans are sent to a trust for the payment of benefits. Benefits under the Account Plans are paid from the Employer's general assets.

The Plan does not credit earnings or interest on your contributions, including on your contributions to the Account Plans.

What are the rules for the Group Health Care, Dental, and Vision Plans if I am absent from work under the Family and Medical Leave Act ("FMLA")?

If you are absent from work on a leave of absence covered by the FMLA, you are entitled to maintain coverage under the Group Health Care, Dental, and Vision Plans. You may continue your coverage or revoke any election you made for the period of FMLA leave. Upon return, you will be reinstated to your coverage under the Group Health Care, Dental, and Vision Plans. If FMLA leave spans two Plan Years, you may make a new election during the same election period (if available) as everyone else. Or you may make a new election within two weeks right after you return from FMLA leave. Your new election will apply to the coverages which are in effect on the date the coverage is reinstated. If you are on FMLA leave, you have the same rights as a non-FMLA participant to make elections. This means you may make elections for a Change in Status as described above.

If you continue coverage, you must pay the premiums for the coverage during your absence. The Plan permits you to use one of the following three methods of payment, so long as the Employer agrees to the method you select:

- (a) *Prepayment.* With the prepayment option, you request the Employer to increase your salary reduction prior to taking a leave of absence. The increased amount covers the premiums that come due during FMLA leave. You may use any taxable compensation, including unused

vacation, paid time off or other leave to fund this increase, so long as all other requirements are met. You may also prepay premiums that come due during FMLA leave using after-tax dollars. If your FMLA leave spans two Plan Years, you may only prepay your premiums for the remainder of the Plan Year in which your leave begins.

(b) *Pay-as-you-go*. With the pay-as-you-go option, you continue to pay premiums on a regular basis throughout FMLA leave. If you continue to receive your pay while you are gone, the premiums will be paid with pre-tax money as if you had not taken the leave. If your FMLA leave is unpaid and you choose this option, you will have to reimburse the Employer at regular intervals for the premiums that come due during the leave using after-tax funds. If you don't make any such after-tax payment to the Employer, the Employer may discontinue your coverage under the Plans. The Employer may also choose to continue your coverage even if you don't make payments. If it does so, it is entitled to recover those payments from you after you return to work from your leave.

(c) *Catch-up*. Under the catch-up option, the Employer will pay your share of premiums while you are on leave. You will re-pay the Employer for your share of premiums when you return from your leave in a manner agreed to between you and the Employer. If you fail to return from leave, your Employer may deduct the amount of premiums you owe from any of your compensation, including accrued but unused vacation or paid time off.

You should contact the Plan Administrator for more information about continuation of coverage under the Group Health Plans during FMLA leave.

What are the rules for other benefit plans if I am absent from work under the Family and Medical Leave Act ("FMLA")?

Your FMLA rights under the Account Plans are discussed in the respective Sections below.

If you are absent from work on a leave of absence covered by the FMLA, the Employer's policies determine whether you are entitled to maintain coverage for benefits other than the Group Health Plans and Account Plans. If the Employer's policies and the terms of the applicable plan permit, you may continue coverage and/or be reinstated in coverage under the Group Critical Illness, Accident, Voluntary Life, Universal Life, and Hospital Indemnity Plans during FMLA leave. The Employer may change its policies at any time. An employee who elects to continue these benefits during FMLA leave must pay their share of premiums. In general, this occurs in the same manner and using the same methods as premium payments for the Group Health Plans during FMLA leave, described in the preceding Q&A. However, employees pay their share of premiums for these benefits after-tax during FMLA leave (just as they do during active employment).

You should contact the Plan Administrator for more information about continuation of coverage under these benefits during FMLA leave.

What if I am absent from work for duty in the uniformed services?

The Uniformed Services Employment and Reemployment Rights Act (“USERRA”) protects your right to participate in the Group Health Care, Dental, and Vision Plans during leaves of absence for active military duty. This means that if you are absent from work due to a period of active duty for less than 31 days, your participation will not be interrupted. If you are absent for between 31 days and 12 weeks, you must pay for your continued coverage under the Plans. You may use the same payment options as an individual qualifying for FMLA leave described above. Please read the summary plan descriptions or plan documents of the Group Health Care, Dental, and Vision Plans for more information.

Does the Plan provide continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (“COBRA”)?

Depending on your election, you may have the opportunity to receive continuation coverage under COBRA through the Group Health Plans and the Flexible Spending Account Plan. COBRA coverage is available to participants in the those Plans according to their terms. This Plan does not provide coverage under COBRA. You must pay the premiums for COBRA with after-tax funds, subject to the rules that are set out in the Group Health Plans and the Flexible Spending Account Plan.

Does the Plan provide coverage pursuant to a Qualified Medical Child Support Order (“QMCSO”)?

The Plan will provide benefits under the Employer’s Group Health Plans as required by any QMCSO. It will also provide benefits to dependent children placed with a Participant or beneficiary for adoption. The Plan will provide these benefits under the same terms and conditions that apply in the case of dependent children who are your biological children. The Plan will enroll the individual according to the benefit option specified in the QMCSO. If the QMCSO specifies a benefit option different than your election, the Employer will enroll you and the alternate recipient as specified in the order. It will reduce your compensation accordingly and use it to pay for the benefits. If the QMCSO does not specify a benefit option, but you are enrolled in one or more of the Group Health Plans, the Employer will enroll the alternate recipient under the same option as you. It will automatically charge you the difference in the cost and contribute this amount to the Plan.

A QMCSO has to satisfy certain specific conditions to be qualified. The Plan Administrator will notify you if it receives a QMCSO that applies to you.

What happens to the Benefit Plans if I terminate my employment during the Plan Year?

If you terminate your employment during the Plan Year, you will not be able to make any more contributions to the Benefit Plans through this Plan. Your coverage under those Benefit Plans will end according to their terms, subject to COBRA as described in the terms of those Benefit Plans.

Can the Employer amend or terminate the Plan?

Although the Employer expects to maintain the Plan indefinitely, it has the right to amend, modify, or terminate the Plan at any time.

Are my benefits taxable?

The Plan is intended to meet the requirements of the Code so that the benefits you receive under the Plan are not currently taxable. To enjoy this benefit, you must comply with the terms of the Plan. However, the Employer does not guarantee the tax treatment to any given Participant. Your individual circumstances may produce a different result. You should consult your own tax advisor.

What happens if my claim for benefits under a Group Health Plan or an Other Benefit Plan is denied?

The Group Health Plans and Other Benefit Plans each contain a claims procedure. Please read the summary plan descriptions, insurance contracts, or plan documents for the relevant Group Health Plan or Other Benefit Plan for its claims procedure.

7. Questions and Answers about the Dependent Care Assistance Plan.

The Plan offers you the opportunity to contribute to the Dependent Care Assistance Plan (the “DCAP”). The DCAP gives you the opportunity to elect to receive income-tax-free reimbursement for some of your eligible dependent care expenses. Under the DCAP, you sign a Salary Reduction Agreement with the Employer to have pre-tax funds contributed to the DCAP instead of receiving all of your regular pay. The DCAP uses these funds to reimburse your eligible dependent care expenses. This arrangement helps you because the benefits you elect are nontaxable. This means you save FICA and income taxes on the amount of your salary reduction.

Who can participate in the DCAP and when does participation begin and end?

Anyone who is eligible to participate in the Flexible Benefits Plan may participate in the DCAP. The DCAP uses the same rules as the Flexible Benefits Plan to determine when you become a Participant, returning your Benefits Election, failure to return a Benefits Election, and participation by individuals who are rehired by the Employer. Section 6 describes these rules.

The DCAP also uses the same rules as the Flexible Benefits Plan for deciding when you stop participating in the DCAP. However, you may continue to incur eligible dependent care expenses until the end of the Plan Year in which you terminate employment or otherwise cease to be an eligible employee, and the corresponding Grace Period, described below. The claims you incur cannot exceed your Account balance.

How does the DCAP work?

If you elect to participate, the DCAP establishes a Dependent Care Reimbursement Account (“Account”) on your behalf. The Account is credited with the portion of your compensation you elected to contribute to the DCAP each payroll period. For example, suppose you expect to incur \$2,600 of eligible dependent care expenses during the Plan Year. If you are paid every week, the DCAP will deduct \$50 from each paycheck. Your Account would be credited with a total of \$2,600, spread equally over 52 paychecks. The amount that you have set aside will accumulate until you submit a documented claim for reimbursement of eligible dependent care expenses.

Who is an “eligible dependent” for whom I can seek reimbursement?

You may be reimbursed for work-related expenses incurred on behalf of your –

(a) Child (or descendent of your child) under the age of 13 who resides with you for more than one-half of the calendar year and who does not provide over one-half of his or her own support;

(b) Spouse, if he or she is mentally or physically unable to care for himself or herself, who resides with you for more than one-half the calendar year; or

(c) Disabled child or other qualified relative who is physically or mentally incapable of caring for himself or herself, who you provide more than one-half of his or her support, and who resides with you for more than one-half of the calendar year.

For purposes of determining who is your Dependent under the DCAP, in the case of divorced parents, a Dependent who is a child shall be treated as a Dependent of the custodial parent and shall not be treated as a Dependent with respect to the non-custodial parent.

What are “eligible dependent care expenses”?

This Summary contains a general list of eligible dependent care expenses. You should consult your own tax advisor for more information. You should also read IRS Publications 17 and 503 for further guidance. These publications contain more information about eligible dependent care expenses.

You Should Claim

- Only amounts paid or payable to someone other than your spouse, your child who is under age 19, or a person for whom you can receive a deduction for tax purposes.
- Child or dependent care expenses that allow you to work or look for work.
- Expenses of qualified daycare centers.
- Household services, such as services of a housekeeper, maid or cook incidental to care of a qualifying dependent.
- Only amounts paid that do not exceed your annual salary reduction.
- Cost of in-home babysitters, pre-school tuition and summer day camps.

- Cost of services provided outside the home if the dependent spends at least 8 hours per day in the home.

You Should Not Claim

- Any items you intend to claim as a credit for federal tax purposes.
- Educational expenses for any child in or beyond kindergarten.
- Amounts in excess of your annual salary reduction.
- Cost of food, clothing, shelter, insurance, medical treatment, or vacations of a qualifying individual.
- Costs for services outside your household at a camp where a qualifying individual stays overnight.

The Plan Administrator decides, in its discretion, what constitutes an eligible dependent care expense subject to reimbursement.

How do I receive my benefits under the DCAP?

When you incur an eligible dependent care expense, you should submit a claim to the DCAP’s Third-Party Administrator, WEX Health, Inc. (the “TPA”). You may obtain a Claim Form or Recurring Dependent Care Request Form (a “Claim Form”) at the TPA’s website or by requesting one at the address below. You may also submit claims using the TPA’s free mobile app, which is available from the Apple App Store or Google Play. You should submit the completed Claim Form to the TPA on its website, by email, through its mobile app, by facsimile, or by mail as follows:

Website:	benefitslogin.wexhealth.com
Mobile app:	WEX Benefits
Fax (toll free):	(866) 451-3245
Email:	forms@wexhealth.com or customerservice@wexinc.com
Mail:	WEX, P.O. Box 2926, Fargo, ND 58108-2926

You may also call the TPA at (866) 451-3399 if you have any questions.

You must include with your Claim Form a written statement from the service provider (e.g., an invoice) associated with each expense that indicates the following: (a) the nature of the expense; (b) the date or dates the services were provided; and (c) the amount of the expense.

The TPA will process the claim once it receives the Claim Form from you. The TPA will reimburse eligible dependent care expenses as soon as possible after it receives and processes the claim. The TPA or Employer will notify you if it determines that your request does not qualify as an “eligible dependent care expense.”

How much can I receive as reimbursement?

If you have enough funds in your Account, you will be reimbursed for your eligible dependent care expenses. If you request reimbursement of more than your current Account balance, the claim will not be paid until additional sums become available in your Account balance or you resubmit

your claim for an amount equal to your current Account balance. If you want the full amount of reimbursement, you must re-file your Claim Form after additional funds become available unless you have a Recurring Dependent Care Request Form on file. The DCAP will not reimburse you for any expenses greater than your annual election. The DCAP will not reimburse you for expenses that arise before the effective date of your Benefits Election. The DCAP will not reimburse you until you have actually paid for the eligible dependent care expenses. The Plan Administrator decides, in its discretion, what constitutes an eligible dependent care expense subject to reimbursement.

When do I submit my claims?

You may submit claims for eligible dependent care expenses at any time during the Plan Year. The DCAP also allows you to submit claims for expenses incurred during the Grace Period following the Plan Year. The Grace Period begins on the first day of the following Plan Year and ends on March 15. You must submit your claims for expenses incurred during the Plan Year or the Grace Period before March 31 of the Plan Year in which the Grace Period occurs. In any case, you will only be reimbursed for amounts up to the remaining balance of your Account.

May I withdraw cash from my Account?

You cannot withdraw cash from your DCAP Account. Your Account balance may only be used to provide reimbursement for eligible dependent care expenses.

Can the Employer amend or terminate the DCAP?

Although the Employer expects to maintain the DCAP indefinitely, it has the right to amend, modify, or terminate the DCAP at any time.

Are my DCAP benefits taxable?

The DCAP is intended to meet the requirements of federal tax laws so that the benefits you receive under the DCAP are not currently taxable. To enjoy this benefit, you must comply with the terms of the DCAP. However, the Employer does not guarantee the tax treatment to any given Participant. Your individual circumstances may produce a different result. You should consult your own tax advisor.

What are the limits on the DCAP benefits I can choose?

The total DCAP benefits you may exclude from income during any calendar year cannot be more than the least of the following: (a) your earned income; (b) if you are married, your spouse's earned income; (c) \$7,500 (\$3,750 if you are married and file separate income tax returns); or (d) the amount set by the Employer, if any.

If your spouse is a full-time student or incapable of self-care, the DCAP deems him or her to have earned income of \$250 per month. The DCAP deems him or her to have \$500 per month of income if you have two or more qualified Dependents for which claims are filed under the DCAP. The Employer has established a minimum DCAP contribution of \$260 per Plan Year or portion thereof.

Can I change my election for DCAP benefits during the Plan Year?

No, unless you have a Change in Status. A Change in Status for the DCAP means one or more of the following:

- (a) Your marriage, divorce, legal separation, annulment, or death of a spouse;
- (b) An event that changes the number of your Dependents, including birth, adoption, placement for adoption of a child (as defined by the Code) or death;
- (c) You, your spouse, or your Dependent terminate or begin employment;
- (d) You, your spouse, or your Dependent change from part-time to full-time employment status or vice versa. This includes a strike or lockout, beginning or return from an unpaid leave of absence;
- (e) An event that causes your Dependent to satisfy or cease to satisfy the requirements for coverage under the DCAP. This includes age or any similar circumstances as provided in the DCAP;
- (f) You or your spouse change work locations leading to a change in dependent care providers and/or costs; or
- (g) The cost of eligible dependent care expenses changes, provided that such change is imposed by a provider that is not your relative (as defined by the Code).

Your change in election must be because of and consistent with your Change in Status. The DCAP uses the same rules as the Flexible Benefits Plan for deciding whether your change in election is because of and consistent with your Change in Status. Section 6 describes these rules.

When should I tell the Employer of my Change in Status?

You must inform the Employer of your new election as soon as possible, but no later than 31 days after the Change in Status occurs. Your new election will be effective not earlier than the first pay period beginning after you return a new Benefits Election to the Plan Administrator.

Can the Employer make other changes to my election?

The Employer may modify your election downward during the Plan Year if necessary to prevent the DCAP from becoming discriminatory within the meaning of the Code. It will notify you if it takes this action.

What are the rules if I am absent from work under the FMLA?

If you are absent from work on a leave of absence covered by the FMLA, you may continue to receive reimbursements for eligible dependent care expenses. You may continue your salary reduction contributions to the DCAP if your leave is paid. If the Employer's policies permit, you

may also make after-tax contributions if your leave is unpaid. The Employer may change its policies at any time. The Plan permits you to use the prepayment option or the pay-as-you-go option, so long as the Employer agrees to the method you select.

(a) *Prepayment.* With the prepayment option, you request the Employer to increase your salary reduction prior to taking a leave of absence. The prepayment occurs on an after-tax basis, and covers contributions that you would otherwise make to the DCAP during FMLA leave. You may use any taxable compensation, including unused vacation, paid time off or other leave to fund this increase, so long as all other requirements are met. If your FMLA leave spans two Plan Years, you may only prepay your contributions for the remainder of the Plan Year in which your leave begins.

(b) *Pay-as-you-go.* With the pay-as-you-go option, you continue to make contributions to the DCAP on a regular basis throughout FMLA leave. If you continue to receive your pay while you are gone, the contributions will be paid with pre-tax money as if you had not taken the leave. If your FMLA leave is unpaid and you choose this option, you will have to forward your DCAP contributions to the Plan Administrator at regular intervals using after-tax funds. If you don't make any such after-tax payment, the Employer may discontinue your coverage.

You may choose to revoke your election during the period of FMLA leave. When you return from FMLA leave, you will be reinstated to your election and make contributions at the same level as before FMLA leave, subject to adjustment due to a Change in Status as described above. A Participant on FMLA leave has the same right to change his or her election for a Change in Status as any other Participant. You should contact the Plan Administrator for more information.

What is the Dependent Care Tax Credit and how does it relate to the DCAP?

Federal tax law permits a taxpayer to claim a credit against their income tax liability equal to a percentage of the taxpayer's eligible dependent care expenses. The credit is limited, and the percentage of expenses a taxpayer may claim generally decreases as adjusted gross income increases. Claiming benefits under the DCAP reduces the base amount for the Dependent Care Tax Credit. Whether the Dependent Care Tax Credit or DCAP provides you with a better tax result depends on a number of factors. These include your tax filing status (e.g., married, single, head of household), number of dependents, etc. You should consult IRS Publications 17, 503, and 504 and your own tax advisor with questions.

What happens if my claim for DCAP benefits is denied?

If your claim for benefits under the DCAP is denied, you should proceed according to the following claims review procedure.

Step 1: *The TPA provides you with notice of its decision.* The TPA will provide you with written notice that your claim is denied as soon as reasonably possible, but no later than 30 days after it receives your claim. The TPA may take up to an additional 15 days to review your claim for reasons beyond its control. It will provide you with written notice that it needs additional time before the end of the 30-day period. If the TPA needs additional time because you need to provide additional information, you will have 45 days to provide that information.

Step 2: *Review your notice carefully.* Once you have received your notice from the TPA, review it carefully. If the TPA denies your claim, the notice will contain the following:

- The reason(s) for the denial and provisions of the DCAP or the Code on which the denial is based.
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information.
- A description of the DCAP's Appeal procedures and the time limits applicable to such procedures.
- A statement of your right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an Appeal.* If you disagree with the TPA's decision, you may file a written appeal with the TPA (an "Appeal"). You must file your Appeal no later than 180 days after the TPA provides you with the notice described in Step 2. You should submit all information identified in the denial notice as necessary to perfect your claim. You may also submit any additional information that you believe would support your claim.

Step 4: *The TPA reviews your Appeal and provides you with notice of its decision.* If the TPA denies your Appeal, it will notify you in writing no later than 60 days after it receives your Appeal. You should review the notice of the TPA's decision. The notice will contain the same type of information that is provided in the initial notice of denial in Step 2.

Additional important information regarding your Appeals:

- The TPA will conduct an independent review at each level of your appeal. This means the same person or his or her subordinate involved in a prior adverse benefit determination will not be involved in the Appeal.
- On Appeal, the claims reviewer will review relevant information that you submit even if it is new information.
- The TPA will give you notice of any internal rules, guidelines, protocols, or similar criteria used as a basis for the adverse determination.

Each Participant has the right to request and obtain documents, records, and other information as it pertains to the DCAP.

What happens to any unused amounts remaining in my Account?

Federal law requires the DCAP to forfeit any unused amount credited to your Account after the Grace Period. If you terminate employment during the Plan Year, your unused benefits are forfeited at the end of the Plan Year, subject to the Grace Period and the deadline to submit claims. Therefore, you should plan very carefully the amounts that you will have credited to these accounts to avoid losing compensation to which you would otherwise be entitled.

Will the Plan Administrator or the TPA send me a statement of my Account?

Yes. On or before each January 31, the Plan Administrator or the TPA will give you a written statement of the reimbursements paid to you during the preceding calendar year.

8. Questions and Answers about the Flexible Spending Account Plan.

The Flexible Benefits Plan offers you the opportunity to contribute to the Flexible Spending Account Plan (“Health FSAP”). The Health FSAP gives you the opportunity to receive income-tax free reimbursement for some of your qualified medical expenses that are not covered by insurance. Under the Health FSAP, you sign a Salary Reduction Agreement with the Employer to have pre-tax funds contributed to the Health FSAP instead of receiving all of your regular pay. The Health FSAP uses these funds to reimburse your qualified medical expenses. This means you save FICA and income taxes on the amount of your salary reduction.

Who can participate in the Health FSAP and when does participation begin and end?

Anyone who is eligible to participate in the Flexible Benefits Plan may participate in the Health FSAP. The Health FSAP uses the same rules as the Flexible Benefits Plan to determine when you become a Participant, returning your Benefits Election, failure to return a Benefits Election, and participation by individuals who are rehired by the Employer. Section 6 describes these rules.

The Health FSAP also uses the same rules as the Flexible Benefits Plan for deciding when you stop participating in the Health FSAP. However, you may continue to incur claims for qualified medical expenses until the end of the month in which you terminate employment or otherwise cease to be an eligible employee. You have 30 days after that date to submit your claims. However, if you are eligible to incur claims under the Health FSAP on the last day of the Plan Year, you may continue to incur claims during the corresponding Grace Period, described below, up to the remainder of your Account balance.

How does Health FSAP work?

If you elect to participate, the Health FSAP establishes a Flexible Spending Account (“Account”) on your behalf. The Account is credited with the portion of your compensation you elected to contribute to the Health FSAP on the first day of the Plan Year. This is true even though you have not actually contributed that amount to the Health FSAP. If you enroll in the Health FSAP after the first day of the Plan Year, the amount you elect will be credited on the first day you are eligible. For example, suppose you expect to incur \$1,300 of qualified medical expenses during the Plan Year. If you are paid each week, the Health FSAP will deduct \$25 from each paycheck. Therefore, under the example, you are entitled to seek reimbursement of the full \$1,300 of your election as of the first day you are eligible.

Who is an “eligible dependent” for whom I can seek reimbursement?

An eligible dependent is one of the following:

- (a) Your child (including stepchild, adopted child, foster child, grandchild, sibling or step-sibling or descendant of such individuals) who: (i) resides with you for more than one-half the calendar year; (ii) does not provide over one-half of his or her own support for the taxable year; (iii) who is age 18 or younger; and (iv) who has not filed a joint return (other than claim for refund) with the individual’s spouse for the taxable year beginning in the calendar year in which the taxable year of the taxpayer begins;

(b) Your child (including stepchild, adopted child, foster child, grandchild, sibling or step-sibling or descendant of such individuals) who is older than 18 years but younger than 24 years if that child: (i) is enrolled and participating as a full-time student at a high school or an accredited college, university, vocational, technical or trade school; (ii) does not provide over one-half of his or her own support; (iii) who resides with you for more than one-half of the calendar year; and (iv) who has not filed a joint return (other than claim for refund) with the individual's spouse for the taxable year beginning in the calendar year in which the taxable year of the taxpayer begins;

(c) Your disabled child (including stepchild, adopted child, foster child, grandchild, sibling or step-sibling or descendant of such individuals) who: (i) is not able to support himself or herself because he or she is mentally or physically incapable of working; (ii) does not provide over one-half of his or her own support; (iii) who resides with you for more than one-half of the calendar year; and (iv) who has not filed a joint return (other than claim for refund) with the individual's spouse for the taxable year beginning in the calendar year in which the taxable year of the taxpayer begins;

(d) A qualified relative who: (i) has a relationship with you as set forth by the Code (such as parent, sibling, etc.); and (ii) receives over one-half of his or her support from you for the calendar year; or

(e) Your child (including step-child, adopted child, or foster child) who has not attained age 26 as of the last day of the previous month.

For purposes of determining who is your dependent under the Health FSAP, if you are divorced or legally separated, your child is considered a child of both parents regardless of who is the custodial parent.

What are “qualified medical expenses”?

Qualified medical expenses mean medical expenses incurred by you, your spouse, or your eligible dependent. Medical care includes amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. It also includes transportation costs and certain lodging costs while away from home primarily for and essential to medical care. Medical care does not normally include cosmetic surgery or similar procedures. These procedures will be included if necessary to correct a deformity arising from or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

Qualified medical expenses only include expenses that have not otherwise been reimbursed through insurance or otherwise. They do not include premiums you pay for health or accident insurance or certain long-term care services. The Plan Administrator decides, in its discretion, whether the claim and information you submitted qualifies as a qualified medical expense.

Are over-the-counter medicines and drugs qualified medical expenses?

Yes. “Medical Expenses” include medicines and drugs as long as the items are legally procured and generally accepted as falling within the category of medicines and drugs. An expenditure that

is merely beneficial to the general health of an individual is not a qualified Medical Expense (vitamins, for example). “Medical Expenses” do not include qualified long-term care services, as defined in Code Section 7702B(c).

“Medical Expenses” can be incurred by the Participant, his or her spouse, and his or her Dependents. An expense constitutes a “Medical Expense” only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Group Health Care Plan, Group Dental Plan, Group Vision Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Expense has been reimbursed elsewhere (e.g., because the group health plan imposes co-payment or deductible limitations), the Health FSAP can reimburse the remaining portion of such Medical Expense if it otherwise meets the requirements of this Article.

How do I submit a claim for benefits under the Health FSAP?

You may make a claim for benefits from your Account in one of two ways. You may complete and submit a written claim for reimbursement (a “Traditional Claim”). Alternatively, you may use an electronic payment card (the “Card”) provided by the Employer or third party administrator to pay the qualified medical expense.

How do I submit a Traditional Claim for benefits under the Health FSAP?

When you incur an eligible medical expense, you may submit a Traditional Claim to the Health FSAP’s Third Party Administrator, WEX Health, Inc. (the “TPA”). You may obtain a Claim Form at the TPA’s website or by requesting one at its address below. You may also submit claims using the TPA’s free mobile app, which is available from the Apple App Store or Google Play. You should submit the completed Claim Form to the TPA on its website, by email, through its mobile app, by facsimile, or by mail as follows:

Website:	benefitslogin.wexhealth.com
Mobile app:	WEX Benefits
Fax (toll free):	(866) 451-3245
Email:	forms@wexhealth.com or customerservice@wexinc.com
Mail:	WEX, P.O. Box 2926, Fargo, ND 58108-2926

You may also call the TPA at (866) 451-3399 if you have any questions.

Your Claim Form must include a written statement from the service provider (e.g., a receipt, explanation of benefits or “EOB”) associated with each expense that indicates the following:

- (a) The name of the person or persons for whom the expenses have been incurred;
- (b) The nature of the expense (e.g., what type of service or treatment was provided). If the expense is for an over-the counter drug, the written statement must indicate the name of the drug;
- (c) The date the expense was incurred;

(d) The amount of the expense; and

(e) That the expenses have not otherwise been paid through an insurance program offered by the Employer or any other employer, or reimbursed from any other source.

The TPA may require you to provide additional documentation to substantiate your claim. The TPA will process claims for qualified medical expenses when it receives the Request for Reimbursement Form from you. The TPA will reimburse you for the qualified medical expense within a reasonable time after it receives and has time to process the claim. If the TPA determines in its sole discretion that the expense is not a “qualified medical expense,” it will notify you of its decision. You cannot submit a Traditional Claim for an expense for which you used the Card.

NOTE: If the administrators of the applicable Group Health Plans automatically submit an EOB to the TPA for processing, you may not have to provide any additional substantiation or certification.

How do I use the Card to pay for qualified medical expenses?

You may also use the Card to pay qualified medical expenses when you incur them. The Employer or TPA will provide you with the terms of the Card through a separate statement, the terms of which are incorporated herein to the extent consistent with the Code. The terms of use for the Card shall be interpreted in a manner consistent with Section 1.125-6 of the Treasury Regulations and any additional guidance published by the IRS, U.S. Department of Treasury, or other authority. The terms may change from time to time. Please visit the TPA’s website, www.wexinc.com.

The TPA’s mobile app, WEX Benefits, also includes information about how to use the Card and how to substantiate expenses paid using the Card. The mobile app is available for free at the Apple App Store or Google Play.

In general, this is how the Card works:

(a) *You must make an election to use the Card.* In order to be eligible for the Card, you must agree in writing to abide by the terms and conditions of the program as set forth herein and in a cardholder agreement (the “Cardholder Agreement”). This includes any fees applicable to participate in the program, limitations as to Card usage, the Health FSAP’s right to withhold and offset for ineligible claims, etc. The Plan Administrator or TPA will give you a copy of the Cardholder Agreement. The Card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the program. The terms of the Cardholder Agreement are incorporated by this reference to the extent consistent with the Code.

(b) *The Card will be turned off when employment or coverage terminates.* The Card will be turned off when you terminate employment or coverage under the Health FSAP. You may not use the Card during any applicable COBRA continuation coverage period.

(c) *You must certify proper use of the Card.* As specified in the Cardholder Agreement, you certify during the applicable election period that the amounts in your FSAP will only be

used for qualified medical expenses, that you have not been reimbursed for the expense, that you will not seek reimbursement for the expense from any other source, and that you will acquire and retain enough documentation for any expense paid with the Card. Failure to abide by this certification will result in termination of Card use privileges.

(d) *You can only use the Card at certain merchants.* The Employer and TPA limit the merchants where you can use the Card to pay for qualified medical expenses. The Card may only be used at merchants approved by the IRS. In general, these merchants include:

(i) Physicians, dentists, vision care offices, hospitals, and other medical care providers (as identified by the merchant category code).

(ii) Drugstores with the merchant category for Drugstores and Pharmacies if, on a location by location basis, 90 percent of the store's gross receipts during the prior taxable year consist of items which qualify as qualified medical expenses.

(iii) Stores that have implemented the Inventory Information Approval System according to the Treasury Regulations.

Please contact the Plan Administrator or TPA if you have any questions regarding eligible merchants.

(e) *You swipe the Card at the merchant like you do any other credit or debit card.* When you incur a qualified medical expense at an eligible merchant, such as a co-payment or prescription drug expense, you swipe the Card at the merchant much like you would a typical credit or debit card. The Health FSAP pays the merchant up to your available maximum reimbursement amount. Every time you swipe the Card, you certify to the Health FSAP that the expense for which payment is being made is a qualified medical expense that you have not been reimbursed from any other source, that you will not seek reimbursement from another source, and that you will acquire and retain enough documentation for any expense paid with the Card.

(f) *You must obtain and retain a receipt/third party statement each time you swipe the Card.* You must substantiate all claims for qualified medical expenses according to Treasury Regulations, the provisions of which are incorporated by this reference. In general, this means you must obtain a third party statement from the merchant (e.g., receipt or invoice) that includes the following information each time you swipe the Card: (i) the nature of the expense (e.g., what type of service or treatment was provided); (ii) if the expense is for an over-the-counter drug, the written statement must indicate the name of the drug; (iii) the date the expense was incurred; and (iv) the amount of the expense.

You should retain this receipt for one year following the close of the Plan Year in which the expense is incurred. Normally, you must submit the third-party statement to the TPA even though the Health FSAP makes payment under the Card. The TPA will notify you when it needs you to provide a third-party statement. You must provide the third-party statement to the TPA within 45 days (or such longer period provided in the communication from the TPA) of the request.

In accordance with applicable guidance, there may be situations in which the TPA does not ask for substantiation related to a Card swipe. You may visit the website sigis.org for a list of approved merchants that have an IRS-approved inventory system in place that does not require you to submit a receipt to verify the eligible expenses. Please see the TPA's website or mobile app for more information.

(g) *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the TPA, you must repay the Health FSAP for the unsubstantiated expense. The deadline for repaying the Health FSAP is set forth in the Cardholder Agreement. The Employer will follow the correction procedures set forth in the Treasury Regulations to correct any improper payments. If you do not repay the Health FSAP within the applicable time period, the Card will be turned off and an amount equal to the unsubstantiated expense will be offset against future qualified medical expenses. If no claims are submitted prior to the date you terminate coverage in the Health FSAP, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay (as specified in the Cardholder Agreement). The Employer may treat the remaining unpaid amount as any other bad debt, which will result in additional gross income for you.

(h) *You can use either the Card or the Traditional Claims approach.* You have the choice as to how to submit your requests for reimbursement of qualified medical expenses. If you elect not to use the Card, you may submit a Traditional Claim as discussed above. You cannot submit a Traditional Claim for any expense for which you used the Card.

When do I “incur” qualified medical expenses?

Generally, you incur a qualified medical expense on the date the services are performed, not the date you receive or pay the bill. You incur expenses for medicines and drugs on the date of purchase. However, you may receive reimbursement for orthodontia expenses where the provider of treatment bills for all or a portion of the treatment in advance. Such expenses are deemed incurred and may be reimbursed in the year in which the expenses are billed.

How much can I receive as a reimbursement?

The entire amount you elect to contribute to the Health FSAP can be reimbursed at any time during the Plan Year. The Health FSAP will not reimburse you for any expenses greater than your annual election, if applicable. The Health FSAP will not reimburse you until you have incurred the qualified medical expense.

When do I submit my claims?

You may submit claims for qualified medical expenses at any time during the Plan Year. The Health FSAP generally does not reimburse any expenses you incurred prior to the effective date of your Benefits Election. The Health FSAP also allows you to submit claims for expenses incurred during the Grace Period following the Plan Year. The Grace Period for a Plan Year begins on the first day of the following Plan Year and ends on March 15. You must submit your claims for expenses incurred during a Plan Year and corresponding Grace Period by March 31 of the following Plan Year.

If you terminate employment or experience a reduction in hours and do not elect COBRA, you may incur claims through the end of the month in which you ceased to be a Participant. You must submit these claims within 30 days after the last day of the month in which you terminate employment or experience a reduction in hours. However, if your termination occurs in December, you may continue to incur claims during the Grace Period, and must submit them by March 31.

If you elect COBRA, you can incur claims during the Plan Year and Grace Period, if applicable. In any case, you will only be reimbursed for amounts up to the remaining balance of your Account.

May I withdraw cash from my Account?

You cannot withdraw cash from your Health FSAP Account. Your Account balance may only be used to provide reimbursement for qualified medical expenses.

Can the Employer amend or terminate the Health FSAP?

Although the Employer expects to maintain the Health FSAP indefinitely, it has the right to amend, modify, or terminate the Health FSAP at any time.

Are my Health FSAP benefits taxable?

The Health FSAP is intended to meet the requirements of federal tax laws so that the benefits you receive are not currently taxable. To enjoy this benefit, you must comply with the terms of the Health FSAP. However, the Employer does not guarantee the tax treatment to any given Participant. Your individual circumstances may produce a different result. You should consult your own tax advisor.

What are the limits on the Health FSAP benefits I can choose?

The maximum annual benefit amount you may elect to receive under the Health FSAP in the form of reimbursements for qualified medical expenses incurred in any Plan Year shall be \$2,500, plus any cost-of-living adjustments provided under the Code Section 125(i) (\$3,500 for 2026). The entire amount you elect to contribute to the Health FSAP can be reimbursed at any time during the Plan Year. The Health FSAP will not reimburse you for any expenses greater than your annual election. The Health FSAP will not reimburse you until you have actually paid for the qualified medical expenses. The Employer has established a minimum Health FSAP contribution of \$260 per Plan Year or portion thereof.

Can I change my election for Health FSAP benefits during the Plan Year?

No, unless you have a Change in Status. However, your election will terminate if you no longer work for the Employer. A Change in Status for the Health FSAP means one or more of the following:

- (a) Your marriage, divorce, legal separation, annulment, or death of a spouse;

(b) An event that changes the number of your Dependents, including birth, adoption, placement for adoption of a child (as defined by the Code) or death;

(c) You, your spouse, or your Dependent terminate or begin employment;

(d) You, your spouse, or your Dependent change from part-time to full-time employment or vice versa. This includes a strike, lockout, beginning or returning from an unpaid leave of absence;

(e) An event that causes your Dependent to satisfy or cease to satisfy the requirements for coverage under the Health FSAP. This includes age, student status, or any similar circumstances; or

(f) Other events that change the employment status of you, your spouse, or your Dependent, if (i) the eligibility conditions for the cafeteria plan or other employee benefit plan of their employer depends upon employment status and (ii) there is a change in that employment status so that one or more of you becomes or ceases to be eligible under the plan.

Your change in election must be because of and consistent with your Change in Status. The Health FSAP uses the same rules as the Flexible Benefits Plan for deciding whether your change in election is because of and consistent with your Change in Status. Section 6 describes these rules.

When should I tell the Employer of my Change in Status?

You must inform the Employer of your new election as soon as possible, but no later than 31 days after the Change in Status occurs. Your new election will be effective not earlier than the first pay period beginning after you complete a new Benefits Election.

Can the Employer make other changes to my election?

The Employer may modify your election downward during the Plan Year if necessary to prevent the Health FSAP from becoming discriminatory within the meaning of the Code. It will notify you if it takes this action.

What are the rules under the Health FSAP if I am absent from work under the FMLA?

If you are absent from work on a leave of absence covered by the FMLA, you may elect to continue or revoke your coverage under the Health FSAP. You may revoke your coverage during the period of FMLA leave. If you revoke your coverage during the FMLA leave, upon return to employment following FMLA leave, you will be reinstated to your coverage under the Health FSAP. The Health FSAP will reduce the maximum amount available following FMLA leave by the amount which you did not contribute during the leave. You will resume the same level of salary reduction contributions following FMLA leave. You also have the same rights to make a new election as a participant who returns from a period of unpaid leave not covered by the FMLA. A Participant on FMLA leave has the same right to change his or her election for a Change in Status as any other Participant.

You may continue your coverage under the Health FSAP during FMLA leave if you pay your contributions during the leave. The Plan permits you to use the prepayment option or the pay-as-you-go option, so long as the Employer agrees to the method you select.

(a) *Prepayment.* With the prepayment option, you request the Employer to increase your salary reduction prior to taking a leave of absence. The prepayment generally occurs on a pre-tax basis, and covers contributions that you would otherwise make to the Health FSAP during FMLA leave. You may use any taxable compensation, including unused vacation, paid time off or other leave to fund this increase, so long as all other requirements are met. If you do not have sufficient compensation to make prepayments on a pre-tax basis, you may request to make prepayments on an after-tax basis. If your FMLA leave spans two Plan Years, you may only prepay your contributions for the remainder of the Plan Year in which your leave begins.

(b) *Pay-as-you-go.* With the pay-as-you-go option, you continue to make contributions to the Health FSAP on a regular basis throughout FMLA leave. If you continue to receive your pay while you are gone, the contributions will be paid with pre-tax money as if you had not taken the leave. If your FMLA leave is unpaid and you choose this option, you will have to forward your Health FSAP contributions to the Plan Administrator at regular intervals using after-tax funds. If you don't make any such after-tax payment, the Employer may discontinue your coverage.

You will not have coverage under the Health FSAP during FMLA leave if you do not make the payments. This means you will not be reimbursed for expenses incurred during the leave. When you return, you may resume coverage as described above. You should contact the Plan Administrator for more information.

What if I am absent from work for duty in the uniformed services?

The Uniformed Services Employment and Reemployment Rights Act ("USERRA") protects your right to participate in the Health FSAP during leaves of absence for active military duty. This means that if you are absent from work due to a period of active duty for less than 31 days, your participation will not be interrupted. If you are absent for more than 31 days, you must pay for your continued coverage under the Health FSAP. You may use the same payment options as an individual qualifying for FMLA leave described above. You may be required to pay the same premiums as a COBRA participant. Please contact the Plan Administrator for more information.

Does the Health FSAP provide continuation coverage under COBRA?

You may have the opportunity to receive continuation coverage in the Health FSAP under COBRA. Continued coverage in the Health FSAP is available for you, your spouse, or your Dependents if there is a loss of coverage due to a qualifying event. A qualifying event means termination of your employment (other than for gross misconduct) or reduction in your work hours, your death, your divorce, or legal separation from your spouse, or your dependent ceases to meet the eligibility requirements for a Dependent.

COBRA will only be offered to qualified Participants who have not spent all of the amounts in their Account. This means that the annual limit elected by the Participant, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the

amount of premiums for COBRA coverage under the Health FSAP for the remainder of the Plan Year.

COBRA coverage will consist of the Health FSAP coverage in force at the time of the qualifying event. A COBRA participant may submit claims up to their elected annual maximum reduced by the reimbursable claims submitted up to the time of the qualifying event. A COBRA participant who pays the applicable COBRA premiums through the end of the Plan Year will be permitted to submit claims during the Grace Period. Any unused amounts will be forfeited at the end of the Grace Period, and COBRA coverage will terminate at the end of the Grace Period.

Unless you elect otherwise, every individual who was covered under the Health FSAP will be covered together for COBRA coverage. Each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate annual coverage limit and separate COBRA premium. Please contact the Plan Administrator for more information.

If you are participating in the Health FSAP under COBRA, you may not enroll in the Health FSAP during the election period.

Does the Health FSAP provide coverage pursuant to a Qualified Medical Child Support Order (“QMCSO”)?

The Health FSAP will provide benefits as required by any QMCSO. It will also provide benefits to dependent children placed with a Participant or beneficiary for adoption. The Health FSAP will provide these benefits under the same terms and conditions that apply in the case of dependent children who are your biological children. The Health FSAP will enroll the individual according to the benefit option specified in the QMCSO. If the QMCSO specifies a benefit option different than your election, the Employer will enroll you and the alternate recipient as specified in the order. It will reduce your compensation accordingly and use it to pay for the benefits.

A QMCSO has to satisfy certain specific conditions to be qualified. The Plan Administrator will notify you if it receives a QMCSO that applies to you.

May I receive a Qualified Reservist Distribution from my Health FSAP Account?

A Qualified Reservist Distribution is a distribution of the balance of your Health FSAP Account if you are a member of a reserve component ordered or called to active duty. The order or call to active duty must be for a period of at least 180 days (or for an indefinite period). If more than one call or order increases the total period of active duty to 180 days or more, you may request a Qualified Reservist Distribution. A participant must request a Qualified Reservist Distribution prior to the end of the Grace Period.

The amount of the Qualified Reservist Distribution is the amount you contributed to your Account as of the date of the request minus the amount you received as reimbursements. The Qualified Reservist Distribution is included in your gross income, subject to employment taxes.

If I participate in the Health FSAP, can I include the same qualified medical expenses as an itemized deduction on my federal income tax return?

No, you may not claim any other tax benefit for the amounts reimbursed by the Health FSAP. You may be able to itemize medical expenses not reimbursed by the Health FSAP. You should consult your own tax adviser.

What happens if my claim for Health FSAP benefits is denied?

If your claim for benefits under the Health FSAP is denied, you should proceed according to the following claims review procedure.

Step 1: *The TPA provides you with notice of its decision.* The TPA will provide you with written notice that your claim is denied as soon as reasonably possible, but no later than 30 days after it receives your claim. The TPA may take up to an additional 15 days to review your claim for reasons beyond its control. It will provide you with written notice that it needs additional time before the end of the 30-day period. If the TPA needs additional time because you need to provide additional information, you will have 45 days to provide that information.

Step 2: *Review your notice carefully.* Once you have received your notice from the TPA, review it carefully. If the TPA denies your claim, the notice will contain the following:

- The reason(s) for the denial and provisions of a Health FSAP or the Code on which the denial is based.
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information.
- If the TPA relied on an internal rule, guideline, protocol, or other similar criterion in making its decision, a copy of the rule, guideline, protocol, or other similar criterion, or, with respect to benefits other than disability benefits, a statement that such rule, guideline, protocol, or other similar criterion will be provided free of charge upon request.
- A description of the Health FSAP's Appeal procedures and the time limits applicable to such procedures.
- A statement of your right to request all documentation relevant to your claim.
- A statement of your right to sue under ERISA following an adverse determination on review.

Step 3: *If you disagree with the decision, file an Appeal.* If you do not agree with the TPA's decision, you may file a written appeal with the TPA (an "Appeal"). The TPA is the Health FSAP's named fiduciary for purposes of Appeals. You must file your Appeal with the TPA no later than 180 days after the TPA provides you with the notice described in Step 2. You should submit all information identified in the denial notice as necessary to perfect your claim. You may also submit any additional information that you believe would support your claim.

The Health FSAP must provide any new or additional evidence considered, relied upon, or generated in connection with a claim. This evidence must be provided as soon as possible, and sufficiently in advance of the due date for the notice of final internal adverse benefit determination so that you have a reasonable opportunity to respond prior to the due date. If the final internal adverse benefit determination will be based on new or additional rationale, the Health FSAP must provide you, free of charge, with the rationale. The rationale must be provided as soon as possible

and sufficiently in advance of the due date for the notice of final internal adverse benefit determination to provide you with a reasonable opportunity to respond prior to the due date.

Step 4: *The TPA reviews your Appeal and provides you with notice of its decision.* If the TPA denies your Appeal, it will provide you with notice of its decision within 60 days after it received your claim. You should review the notice of the TPA's decision. The notice will contain the following:

- The reason(s) for the denial and provisions of the Plan or the Code on which the denial is based.
- A statement that you are entitled to receive without charge reasonable access to any document: (1) relied on in making the determination, (2) submitted, considered or generated in the course of making the benefit determination, (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (4) that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;
- A statement describing your right to receive information about the procedures and your right to bring a civil action under ERISA Section 502(a); and
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Other important information regarding your Appeals:

- The TPA will conduct an independent review of your Appeal. This means the same person or his or her subordinate involved in a prior adverse benefit determination will not be involved in the current Appeal.
- On Appeal, the claims reviewer will review relevant information that you submit even if it is new information.
- The TPA will consult a health care professional if the Appeal involves whether an expense has a medical care purpose that meets the requirements of the Health FSAP (e.g., whether the expense was cosmetic surgery not related to a personal injury or congenital abnormality). It may consult with a vocational expert. It will identify any medical or vocational experts it consulted, even if it did not rely on their advice. The health care professional consulted will not be the individual who was consulted during the adverse benefit determination that is the subject of the Appeal, nor the subordinate of any such individual.
- The TPA will give you notice of any internal rules, guidelines, protocols, or similar criteria used as a basis for the adverse determination.
- You cannot file suit in federal court until you have exhausted these Appeals procedures, however, you have the right to file suit under ERISA Section 502 following an adverse decision on Appeal.
- Each Participant has the right to request and obtain documents, records, and other information as it pertains to the Health FSAP.

What happens to any unused amounts remaining in my Account?

Federal law requires the Health FSAP to forfeit any unused amount credited to your Account after the Grace Period and the deadline to submit claims. If you terminate employment during the Plan Year, your unused benefits are forfeited after you terminate employment, unless you elect COBRA, in which case your benefits are forfeited at the end of Grace Period, after the deadline to submit claims expires. Therefore, you should plan very carefully the amounts you will have credited to your Account to avoid losing compensation to which you would otherwise be entitled.

What rights do I have under ERISA for the Health FSAP?

The Employee Retirement and Income Security Act of 1974 (“ERISA”) grants certain rights to Participants under the Health FSAP. ERISA entitles all plan Participants to the following:

(a) You may examine all documents governing the Health FSAP without charge. These include the insurance contracts, summary plan description, plan document, and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor. The Employer will make the documents available at the Plan Administrator’s office. They may also be available at other specified locations.

(b) You may obtain copies of all plan documents and other plan information. These include the plan document, copies of the latest annual report (Form 5500 series), and updated Summary Plan Description. The Plan Administrator will provide them upon written request. It may charge a reasonable amount for the copies.

(c) You will receive a summary of the Health FSAP’s annual financial report (if any) from the Plan Administrator.

(d) You may continue health care coverage for yourself, spouse, or Dependents if there is a loss of coverage under the Health FSAP as a result of a qualifying event under COBRA. You or your dependents may have to pay for such coverage. Please review the portion of the Summary Plan Description and the documents governing the Health FSAP for the rules governing your COBRA continuation coverage rights.

ERISA also imposes duties upon the people responsible for the operation of the Health FSAP. These individuals are called “fiduciaries” of the Health FSAP. Fiduciaries have a duty to act prudently. They must act in the interest of you, other participants, and beneficiaries. No one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or from exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done. You may also obtain copies of documents relating to the decision without charge. You have the right to have the Health FSAP review and reconsider your claim.

ERISA provides several steps you can take to enforce the above rights. For instance, if you request materials from the Health FSAP and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the

materials. It may also order the Plan Administrator to pay you up to \$110 a day until you receive the materials. The court may decide not to enforce a penalty if the Plan Administrator did not send the materials because of reasons beyond its control. You may file suit in state or Federal court if you have a claim for benefits that is wholly or partially denied or ignored. You may file suit in Federal court if you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a domestic relations order or qualified medical child support order. The Health FSAP's fiduciaries may not misuse the Health FSAP's money or discriminate against you for asserting your rights. If they do, you may seek assistance from the U.S. Department of Labor. You may also file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Please contact the Plan Administrator if you have any questions about the Health FSAP. You may have questions about this statement or your rights under ERISA. If so, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor. Your telephone directory should list the address. You may also ask the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

9. Conclusion. This Summary Plan Description is intended to briefly highly the provisions of the Plans. The Employer intends this Summary to be accurate. However, the Plans will control any conflict between this Summary and the Plans. You should consult with the Plan Administrator concerning the actual terms of the Plans if you have questions.