forma | KAPITUS

2026 Open Enrollment

November 2025

Agenda

01. Understanding your benefits

02. Navigating Forma

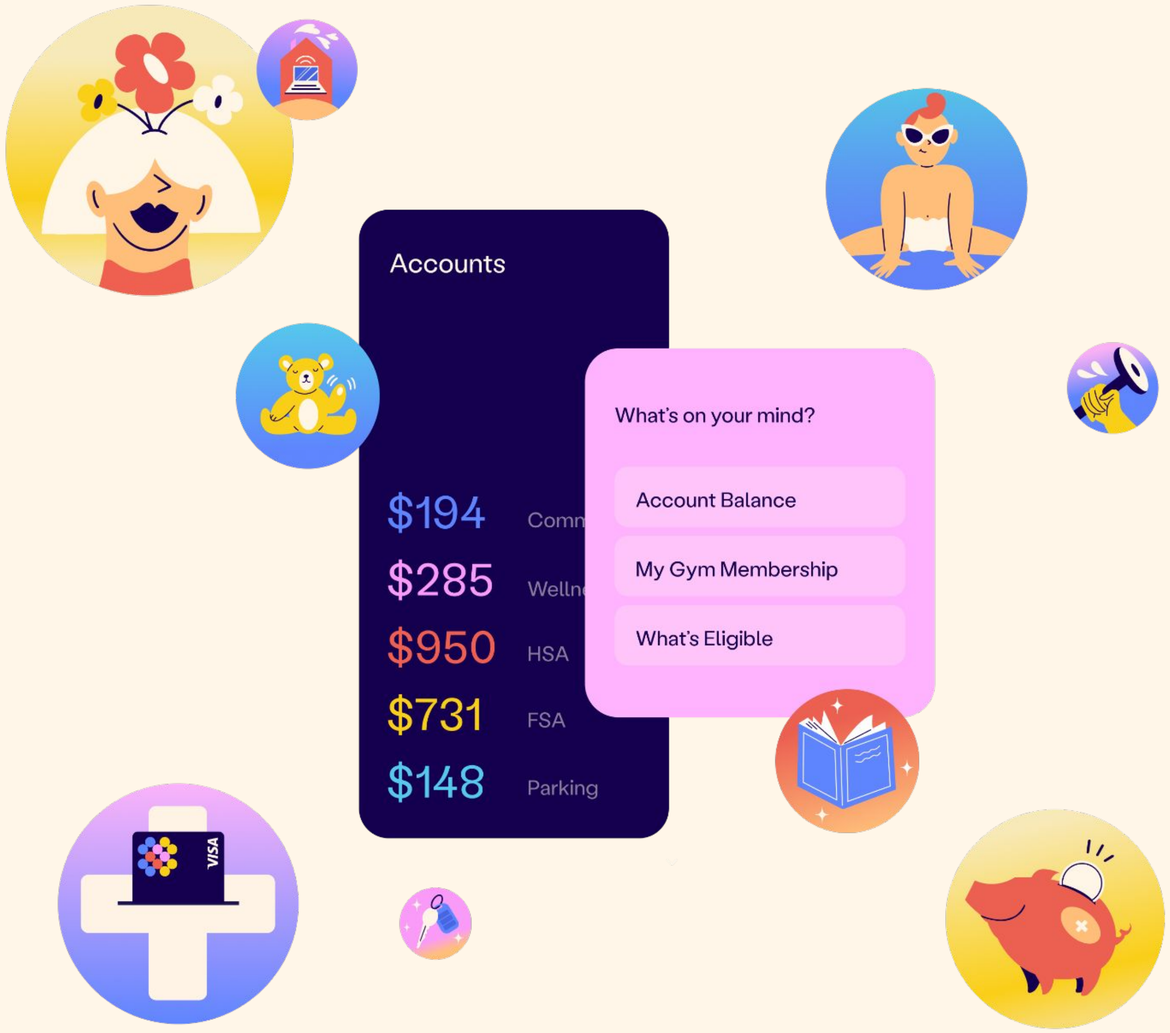
03. Ways to spend

04. Forma Support

Understanding your benefits

Your benefits on Forma

- Pre-tax programs
  - Healthcare FSA
  - Commuter (transit/parking)
- Employer-sponsored programs
  - Kapitus Connect
  - Kapitus Academy
  - Kapitus Comfort



Pre-tax Plan Overview

Plan Name	Annual IRS Maximum	Eligible Expenses	Who's covered?	Funding
Healthcare FSA (FSA)	$1,133.33 (for short plan year) $3,400 (for full plan year)	+ Medical + Dental + Vision + Pharmacy	+ Employee + Employee's dependents	Front loaded, entire annual election is available for use on the plan effective date
Parking	$340 / month	+ Parking garage + Parking meter + Parking lot	+ Employee	Funded with contributions made each pay period over the course of the plan year
Transit	$340 / month	+ Public transportation + Bus + Train + Ferry	+ Employee	Funded with contributions made each pay period over the course of the plan year

Healthcare FSA

- Allows you to contribute to and spend funds on a tax-free basis
- Pay for eligible expenses for you and your tax dependents
- Eligible expense types include medical, dental, vision, pharmacy and some over-the-counter medication and supplies
- Spend via Pre-tax Forma Card or file a claim for reimbursement
- Run-out period: 7/30/2026 (short plan year)
- Run out period: 7/30/2027 (long plan year)

$1,133.33

Maximum contribution available January 1

$680

Maximum carryover into 2026 (for short and long plan years)

Commuter

+ Transit and Parking
+ Pay for eligible transit and parking expenses to and from work
+ Monthly benefit
+ Spend via Pre-tax Forma Card or file a claim for reimbursement
+ Funds become available as payroll deductions are taken throughout the plan year
+ Commuter benefits are funded per pay period
+ If you'd like to make an additional election above the pre-tax monthly limit, you may make post-tax contributions of up to $500 per month

$340

Maximum monthly
2026 contribution for Transit

$340

Maximum monthly
2026 contribution for Parking

Key Dates - 2026 Plan Year

Plan extension	Deadline to Incur Expenses	Deadline to Submit Claims
Run-out period (FSA) - claim submission only - (short plan year)	April 30, 2026	July 30, 2026
Run-out period (FSA) - claim submission only - (long plan year)	April 30, 2027	July 30, 2027

Maximum Carryover Amount (FSA)	$680
Card Issuing Emails Begin	December 1, 2025

Kapitus Connect - Overview

Program Overview

The Kapitus Connect LSA program is designed to provide support for a variety of eligible expenses for categories such as caregiving, fitness activities and equipment, food, home office, pet related services, and wellbeing services. Instead of implementing benefits that you may or may not use, this program is meant to provide you with flexible options that are most relevant to you.

Eligible Employees

All Eligible Employees. Two class types depending on job function. Same eligibility of expenses.

Funding Details

Monthly funded benefit. The account resets at the end of each year.

Kapitus Connect - Eligible Expenses

Eligible Categories	Examples
Clothing and Shoes	Running shoes, hiking shoes, etc
Caregiving	Childcare day camp, extended care, long term care insurance
Fitness Accessories	Fitness tracker, sleep tracker, body scale
Fitness Activities	Athletic event fees, meditation, gym & class fees, personal training
Fitness Equipment	Biking, home gym equipment, motorized vehicles, sports equipments
Digital Health	Fitness apps, meditation apps, nutrition apps, sleep aid apps
Financial Wellbeing	Financial consulting services, tax prep services
Skills Development	Class Material/Supplies/Equipment, In-Person Learning, Online Learning
Food	Grocery, Meal kits, dine-in food, take out food, grocery delivery expenses
Wellbeing Services	Massage therapy, massage equipment, hair care, spa/sauna

Kapitus Academy - Overview

Program Overview

The Kapitus Academy tuition reimbursement program is designed to provide support for specific educational activities (university programs, continuing education, and student loan repayment). Contingent on meeting course requirements and passing grade for reimbursement.

Eligible Employees

All full-time Kapitus employees who have been with the company for at least one year and are in good standing.

Funding Details

Annual Benefit Amount: $5,000 USD. The account resets at the end of each year.

Kapitus Comfort - Overview

Program Overview

The Kapitus Comfort Work from Home program is designed to provide support for a variety of eligible expenses like desktop equipment, desks, chairs, cables and cords, and more.

Eligible Employees

Any new hire on or after January 1, 2026 is eligible.

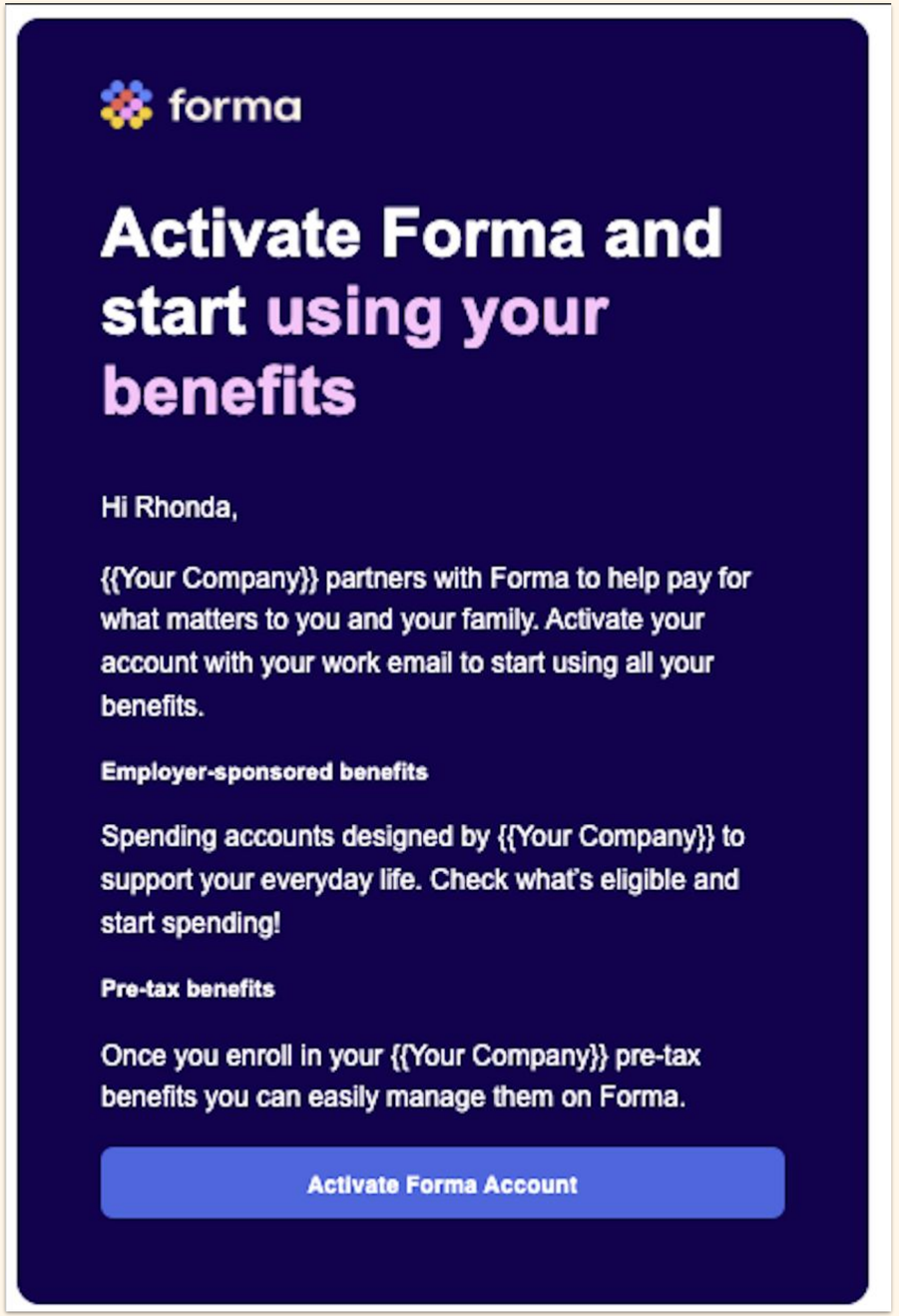
Funding Details

One Time Funded Benefit: $300 USD. The account resets after one year.

Navigating Forma

Activating your Forma account

+ Forma will send you a Welcome Email
+ Click the link in the email to begin activating your Forma account



Accessing your Forma account

You can sign in via any of the following methods

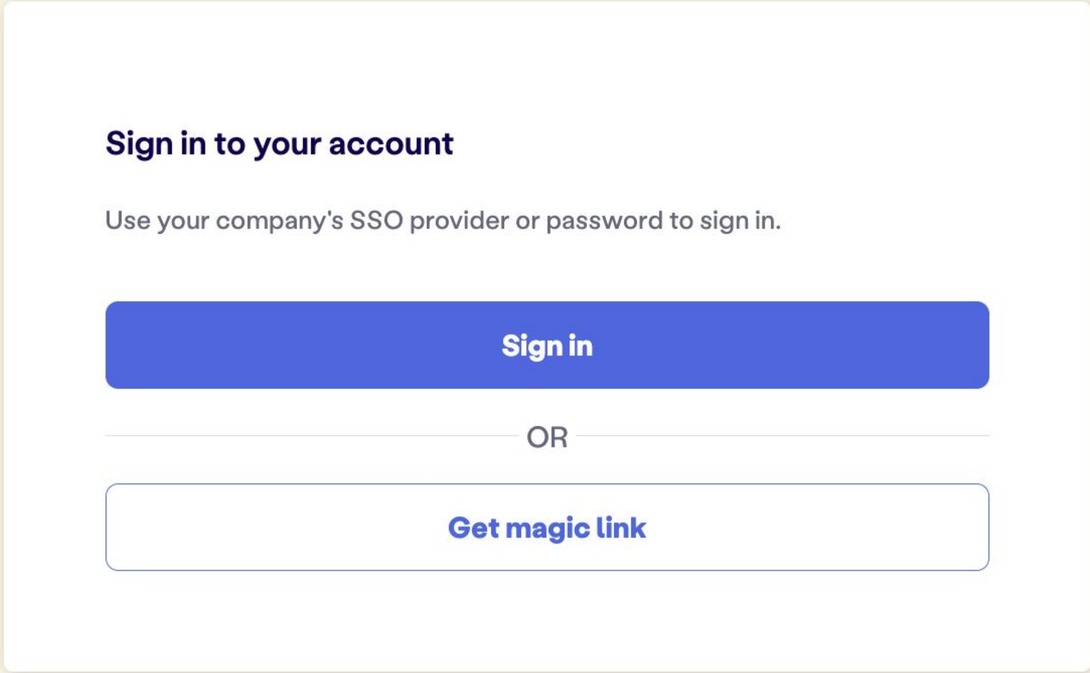
First time / new hires only

1. Clicking the link in your welcome email

After go live

2. Visit https://client.joinforma.com/ and sign in via SSO (Okta)

3. Select the Forma tile in your Okta dashboard

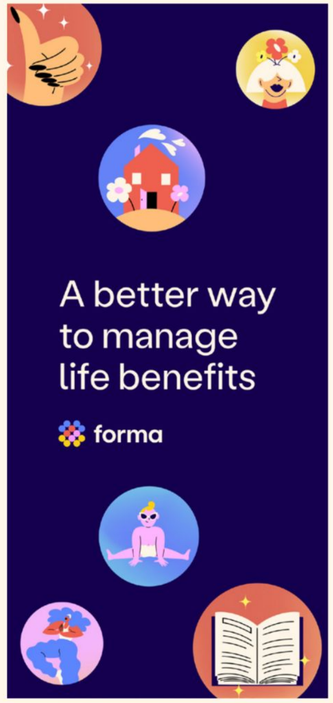


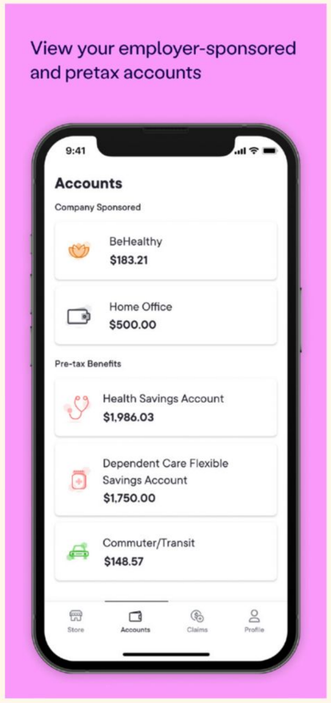
Access your benefits on the go with the Forma app

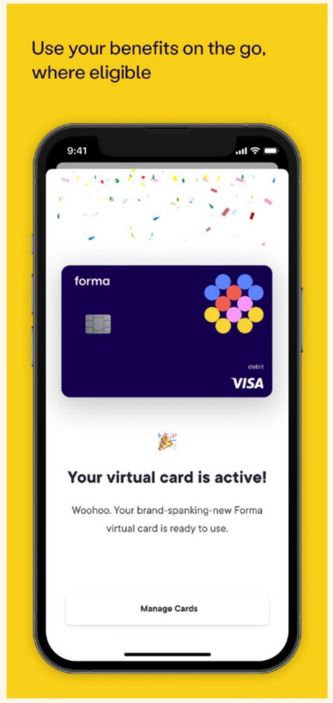
Download the Forma App on iOS & Android

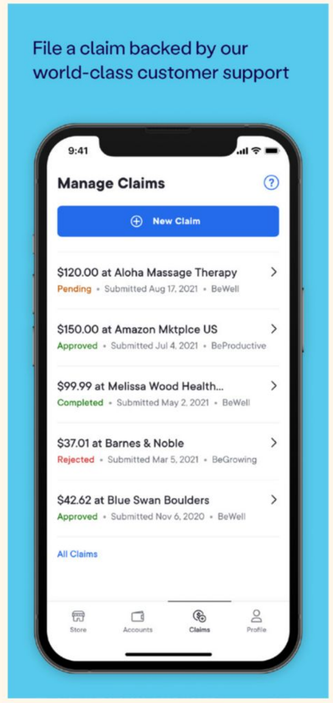
Download on the App Store

GET IT ON Google Play







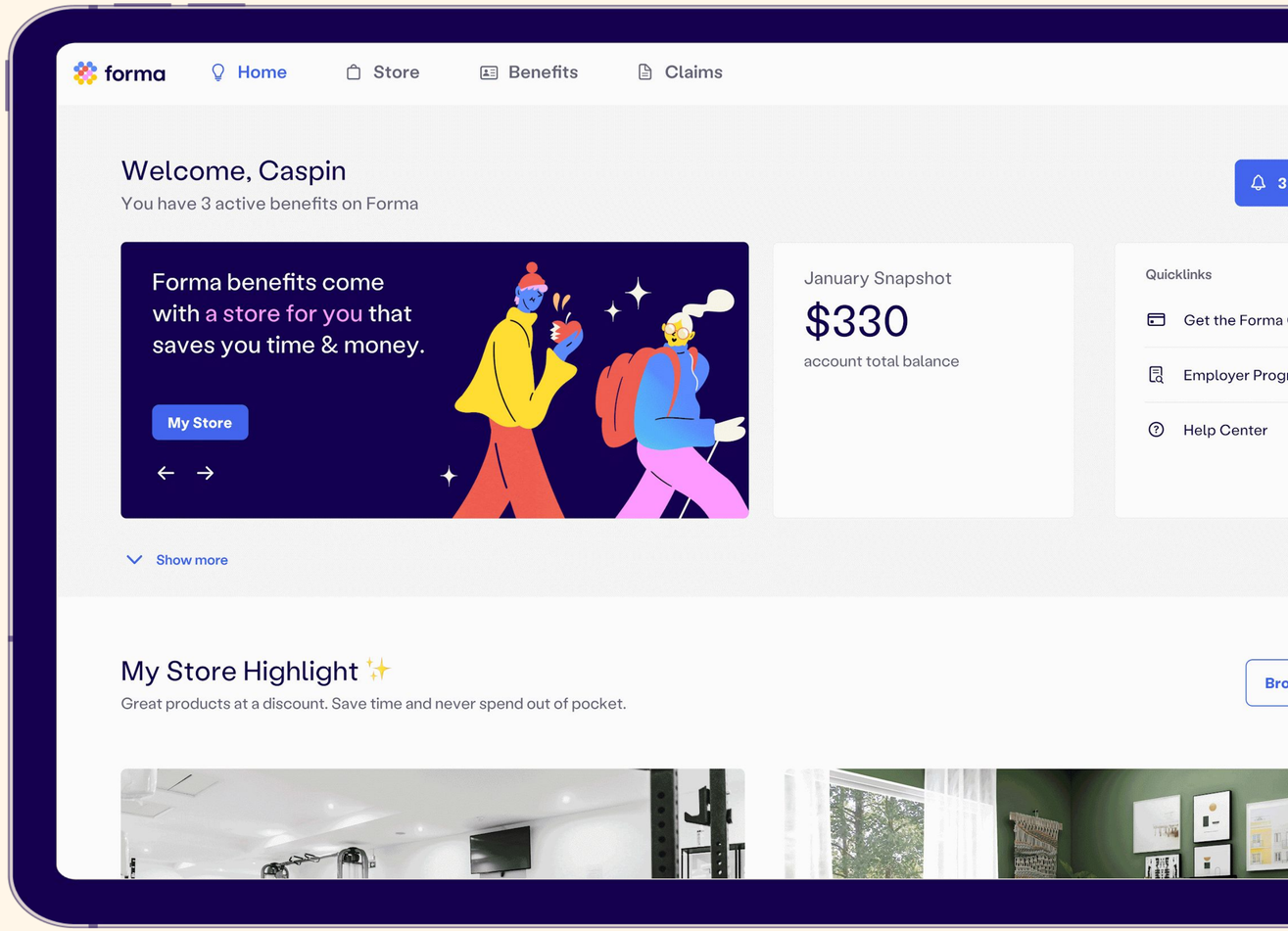


To log in:

+ Enter your email address
+ Select ‘Get Magic Link’
+ Use the link that’s sent to your inbox!

Navigating Forma

+ Benefits management
+ Filing a claim
+ Link to the FSA / HSA Store
+ Messaging with Forma Support (24/5)
+ Forma Card management



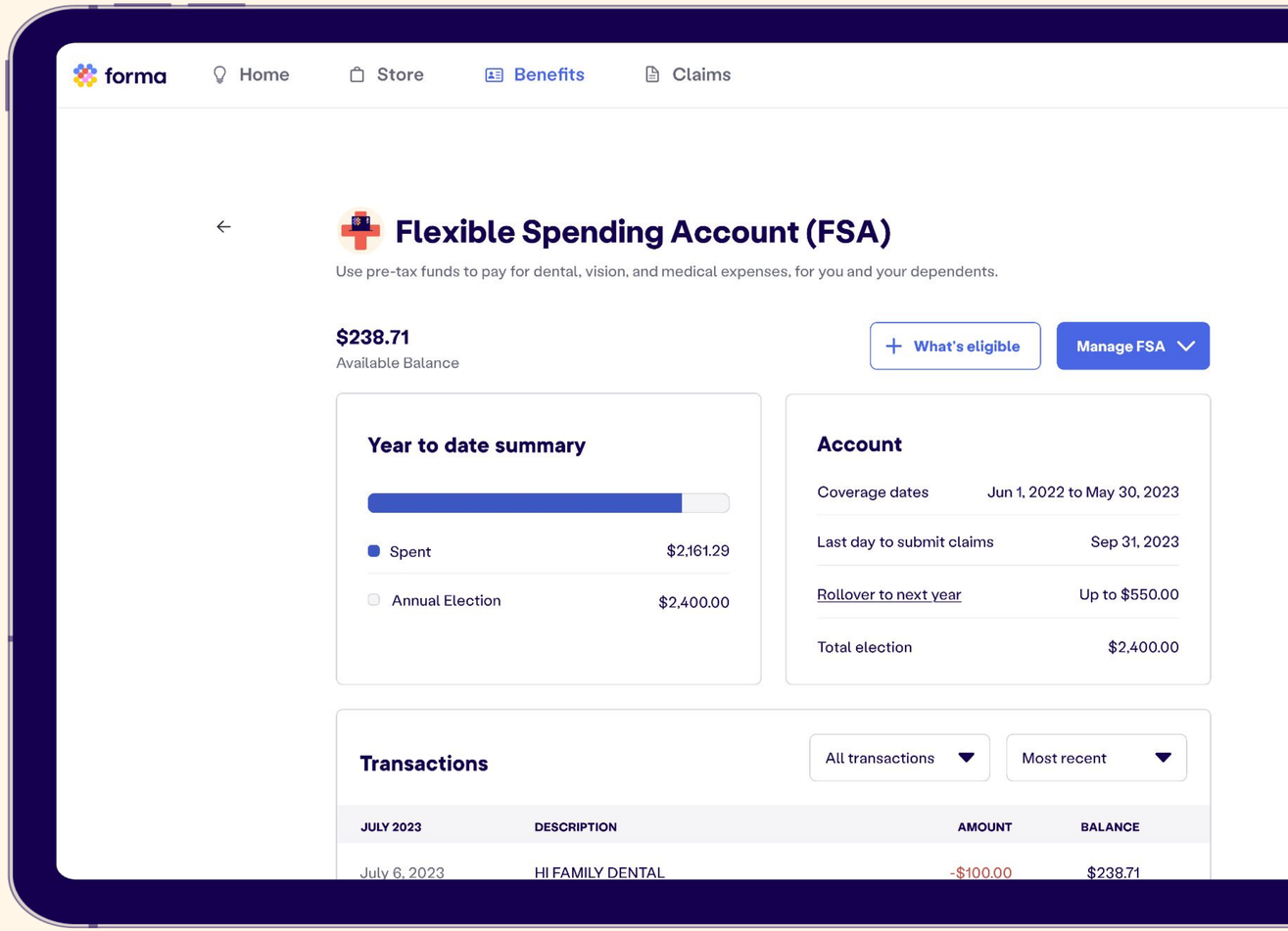
Your benefits

Benefit details

1. Annual election
2. Amount spent
3. Plan start and end date
4. Last day to submit claims
5. Carryover information (if applicable)

Transaction history

1. Merchant
2. Type (card, claims)
3. Status (complete, rejected)
4. Amount

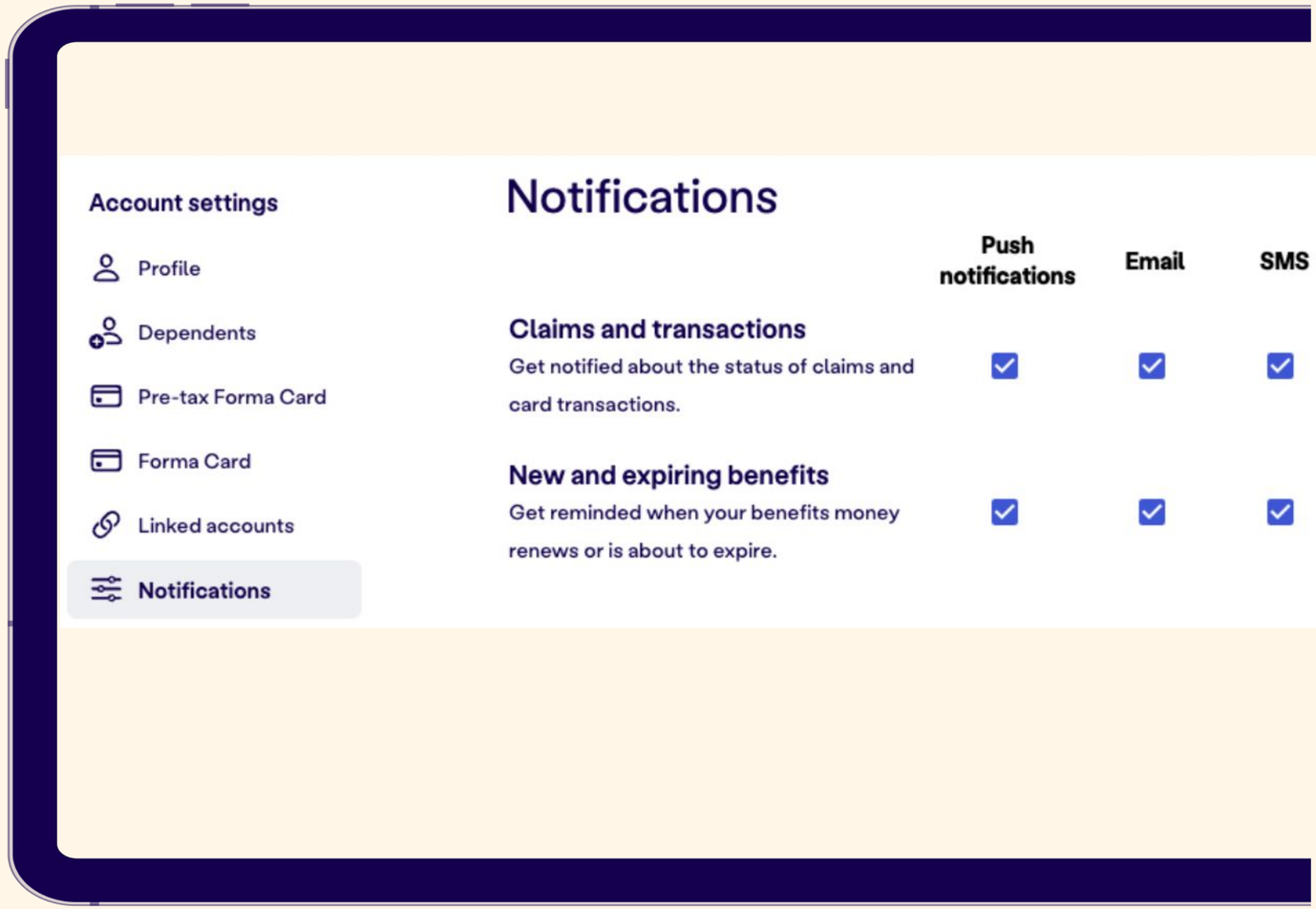


Managing your notifications

Notifications can be found through your profile on Forma

1. Log into your Forma account
2. Navigate to your profile
3. Select “View or edit profile”
4. Under account settings, click “Notifications”

More information can be found here.

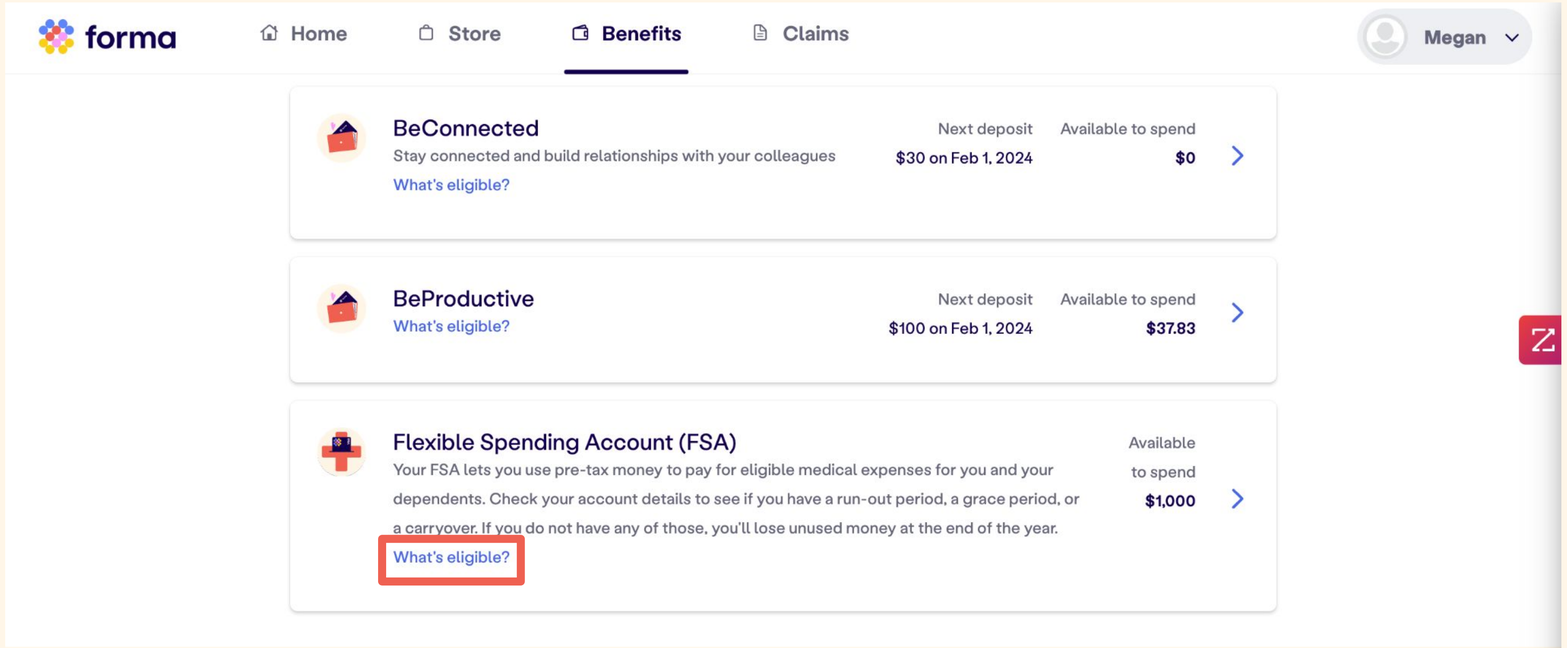


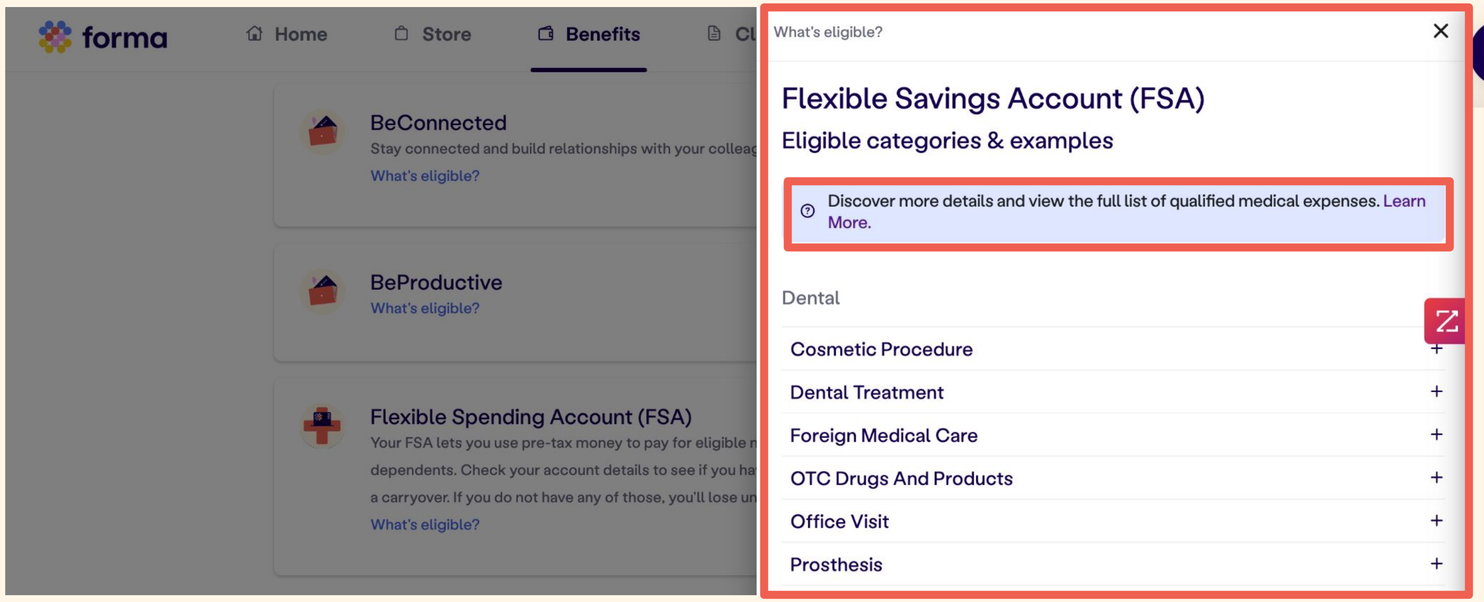
What's eligible?

Navigate to Benefit program

1. Select "What's Eligible"
2. Review the eligibility drawer
3. Use the + to see examples under each eligible item
4. Select the "Learn More" to see a full list of eligible items including items that require a prescription or Letter of Medical Necessity (LMN)

A full list of eligible items can be found here with links to more resources.





What's eligible?

Common eligible items that require a Letter of Medical Necessity (LMN) include:

- Aloe Vera
- Air Purifiers & filters
- Ergonomic chairs or household goods
- Baby food
- Sleep coaching
- Ear plugs
- Orthopaedic shoes and arch support
- Scale for food, pedometer & other weight loss aids
- Fidget tools & grip strengthener
- Alternative medicine like chinese herbs
- Collagen injections
- Hair treatment
- Massage therapy
- Health Related books and classes
- Supplements & Vitamins

More about Letters of Medical Necessity here.

Common eligible items that require a prescription (RX) include:

- Antidepressants
- Birth Control
- Prescription pills

Common eligible items that do NOT require a prescription (RX) that you can purchase OTC include:

- Acetaminophen
- Ibuprofen
- Allergy and Sinus
- Morning after pill / condoms
- Acne medication, anti - itch cream, antifungal foot care
- Fertility tests
- First aid including bandages, gauze, slings and more
- Smoking cessation
- Sunscreen
- More!

Ways to Spend

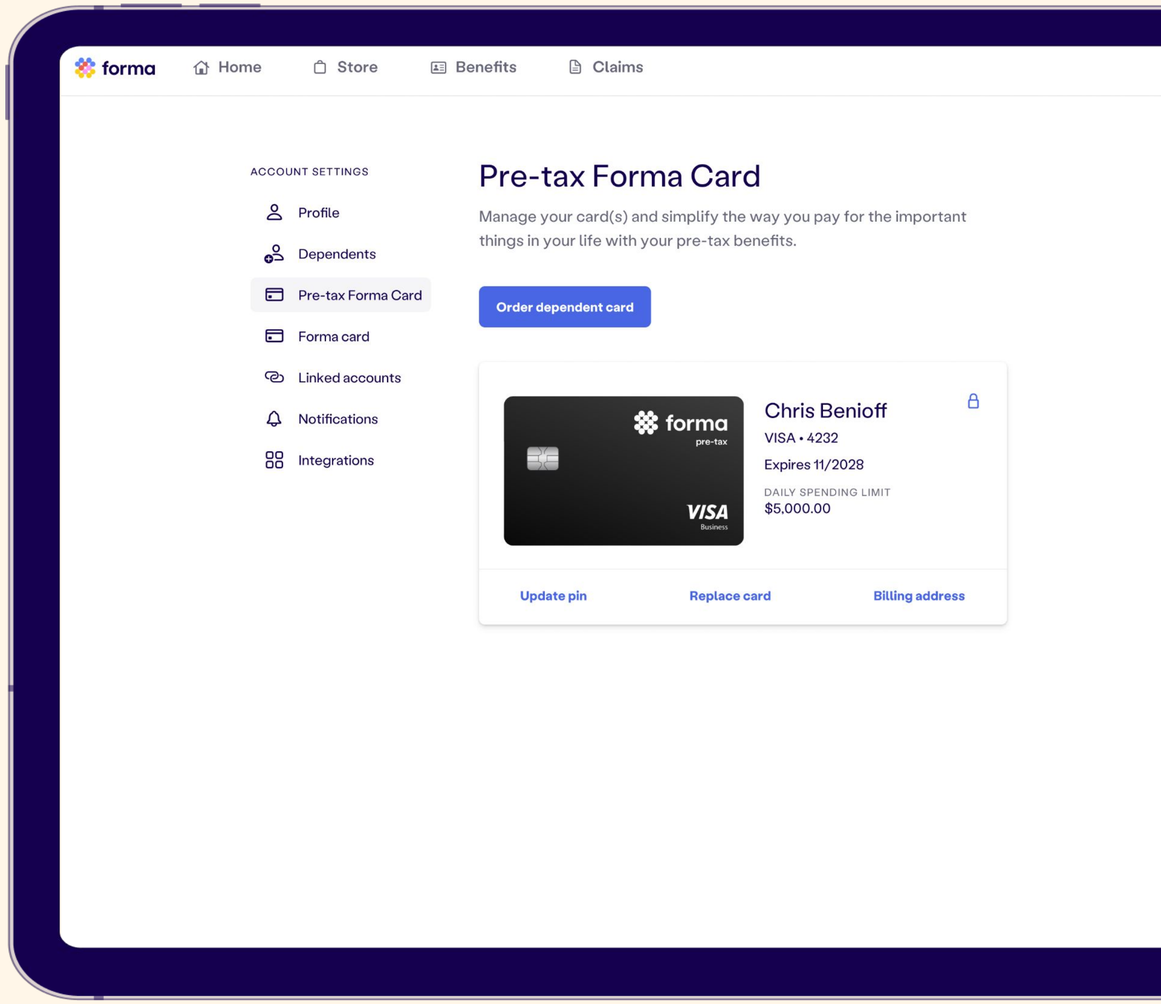
Requesting your pre-tax Forma card

When Forma receives enrollment information for your non-HSA pre-tax benefits (FSA, Commuter) you will receive an email asking to confirm your mailing address, legal name, and phone number. **Please confirm this information in order to be sent your card.**

Once confirmed your pre-tax Forma card will be issued. Alternatively, wait until the plan year start and order your card on Forma.

To order a pre-tax Forma card:

1. Log in to Forma
2. View or edit profile
3. Pre-tax Forma Card
4. Order new card



Pre-tax Forma Card

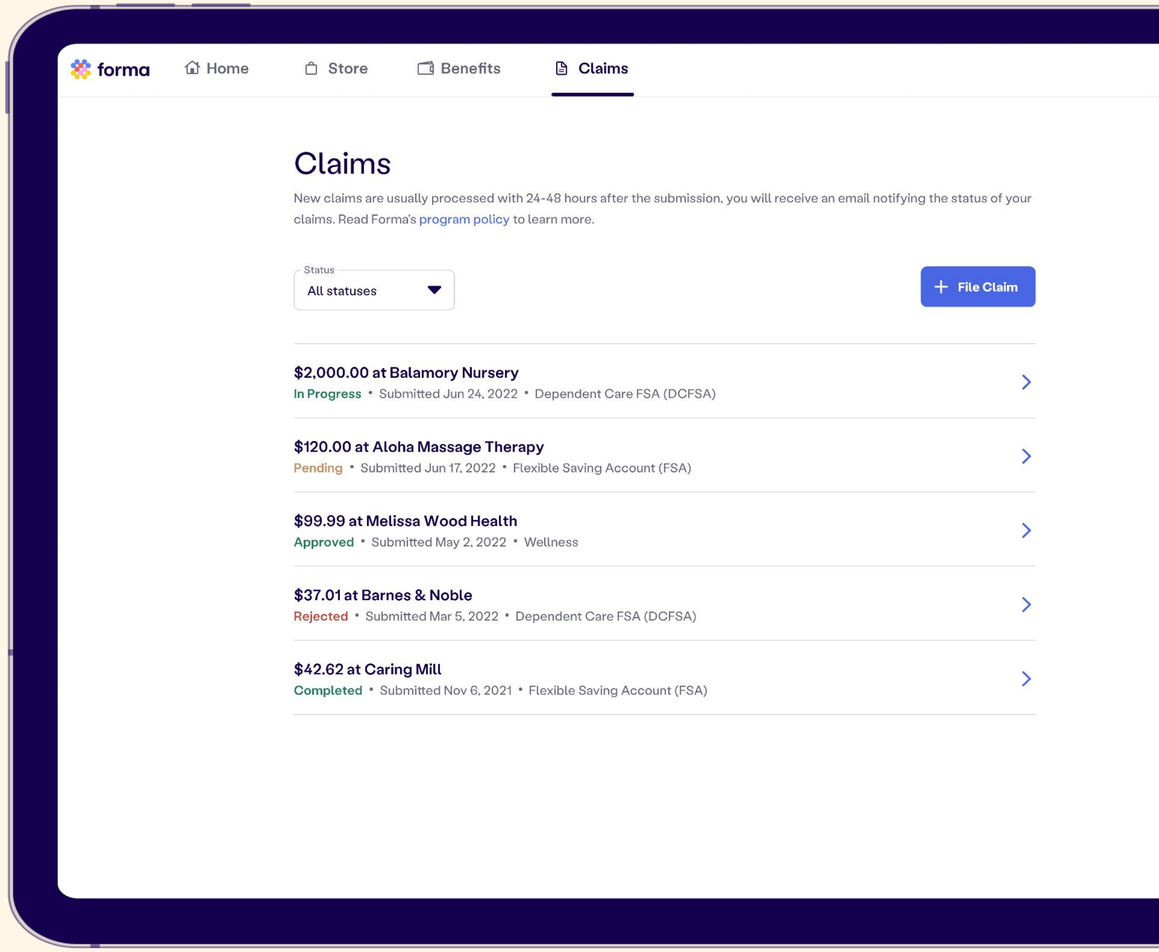
Use the Pre-tax Forma Card to pay for eligible FSA and Commuter products and services.

+ Automatically verified eligibility at the point-of-service
+ No need to pay out-of-pocket
+ Keep your receipt! It may be required if your transaction was made at a store that sells both eligible and ineligible pre-tax items (ex: CVS, Walmart, Amazon).

File a claim

Locate the navigation bar at the top and select **Claims**

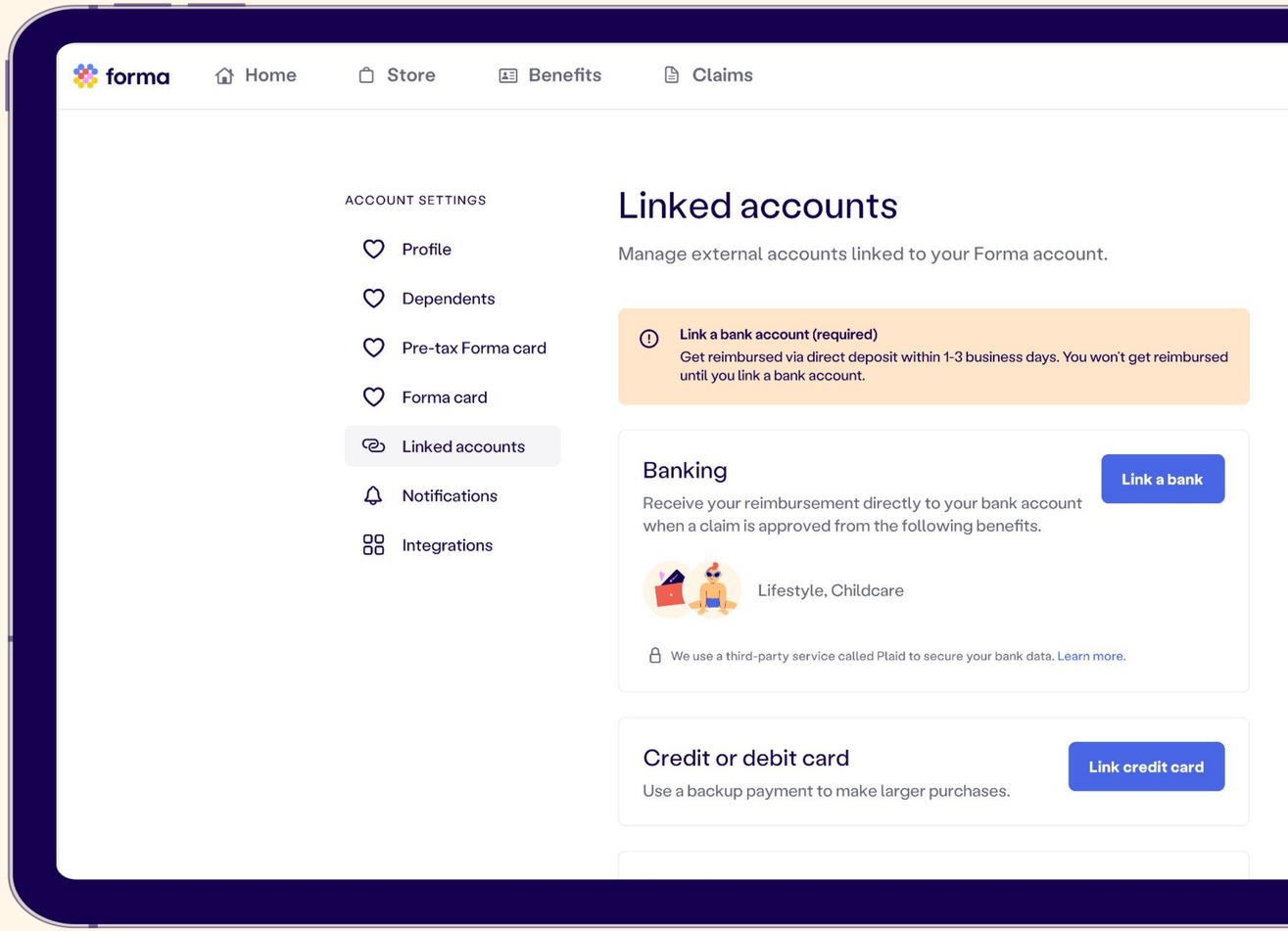
+ Complete claim submission page
+ Claim is reviewed within 48 hours
+ Get reimbursed automatically via direct deposit (FSA, Commuter, employer-sponsored programs)



Direct Deposit

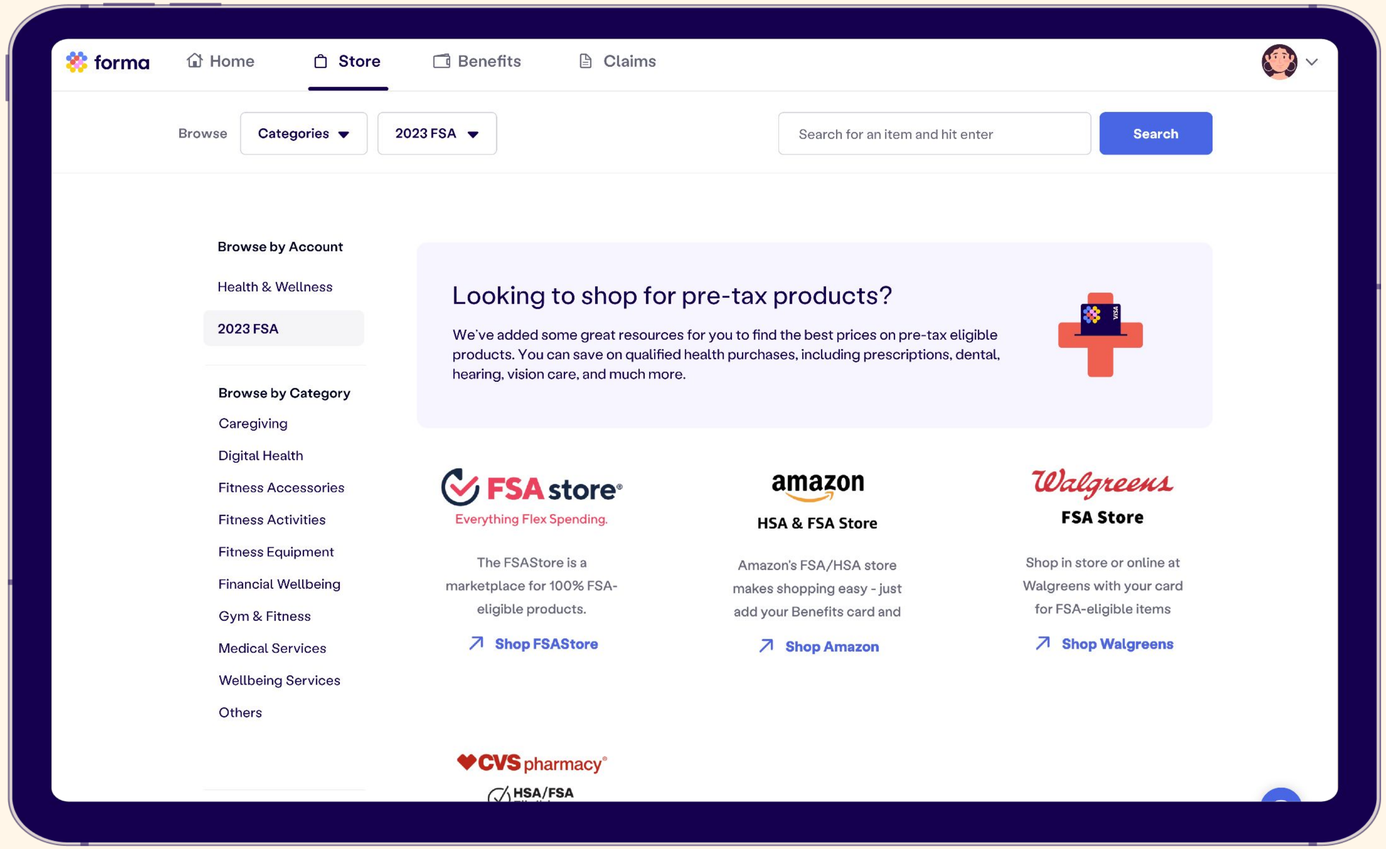
Locate the navigation bar at the top and select **Settings**

+ View and edit profile
+ Select Linked Accounts
+ Select “Link my bank” and follow either the manual linking instruction or use the Plaid link option to electronically connect.
+ You’ll need to make sure to do this ahead of any claims submissions
+ Step by step instructions here



Pre-tax store

Forma links you directly to pre-tax FSA and HSA stores so you can find pre-tax items guaranteed to be eligible.



Forma Support & Next Steps

We’re here to help!

Forma Support

Contact us via messenger or email at

support@joinforma.com

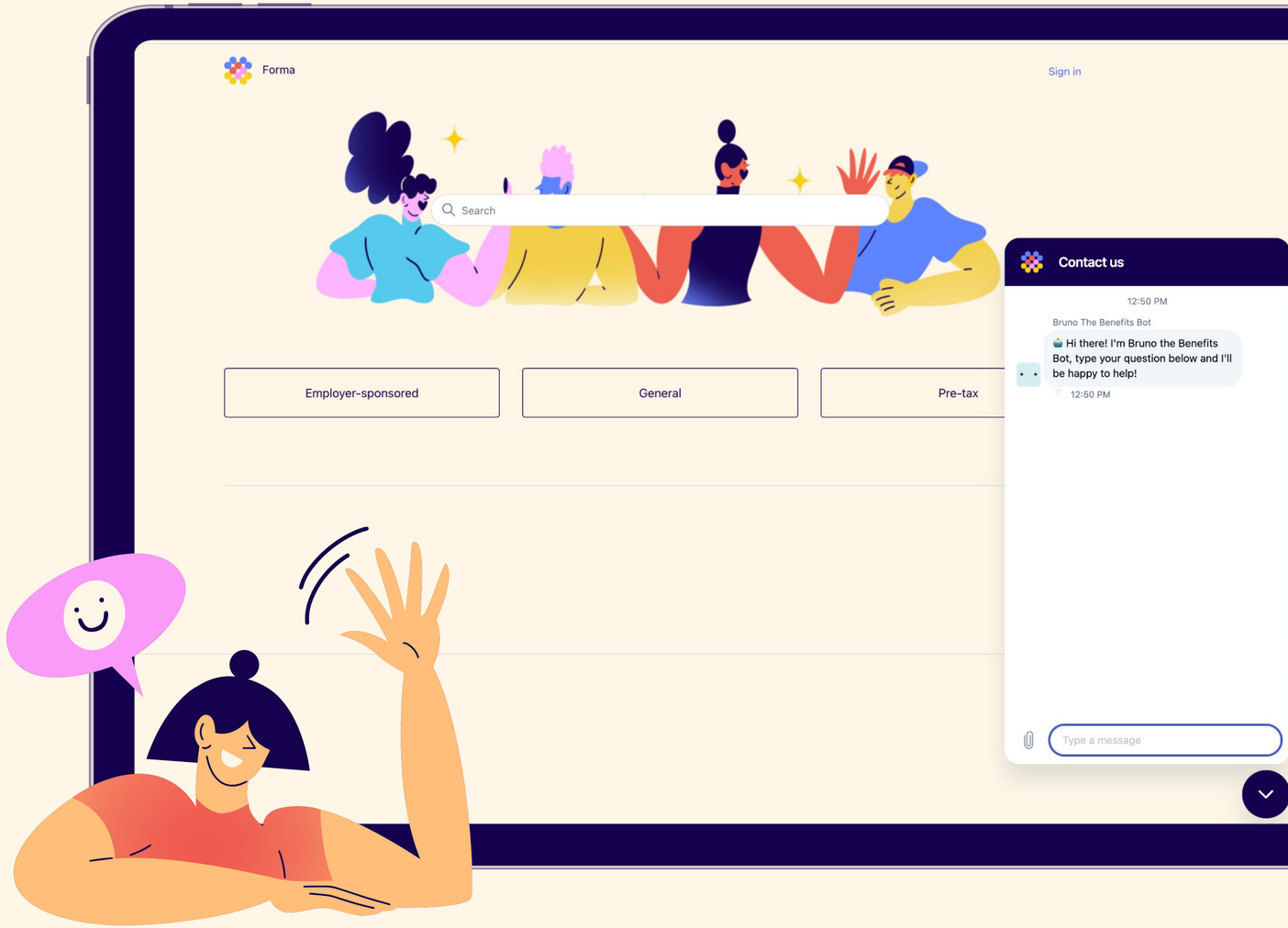
Help Center

Answers to your FAQs!

Pre-tax Phone

844-902-2902

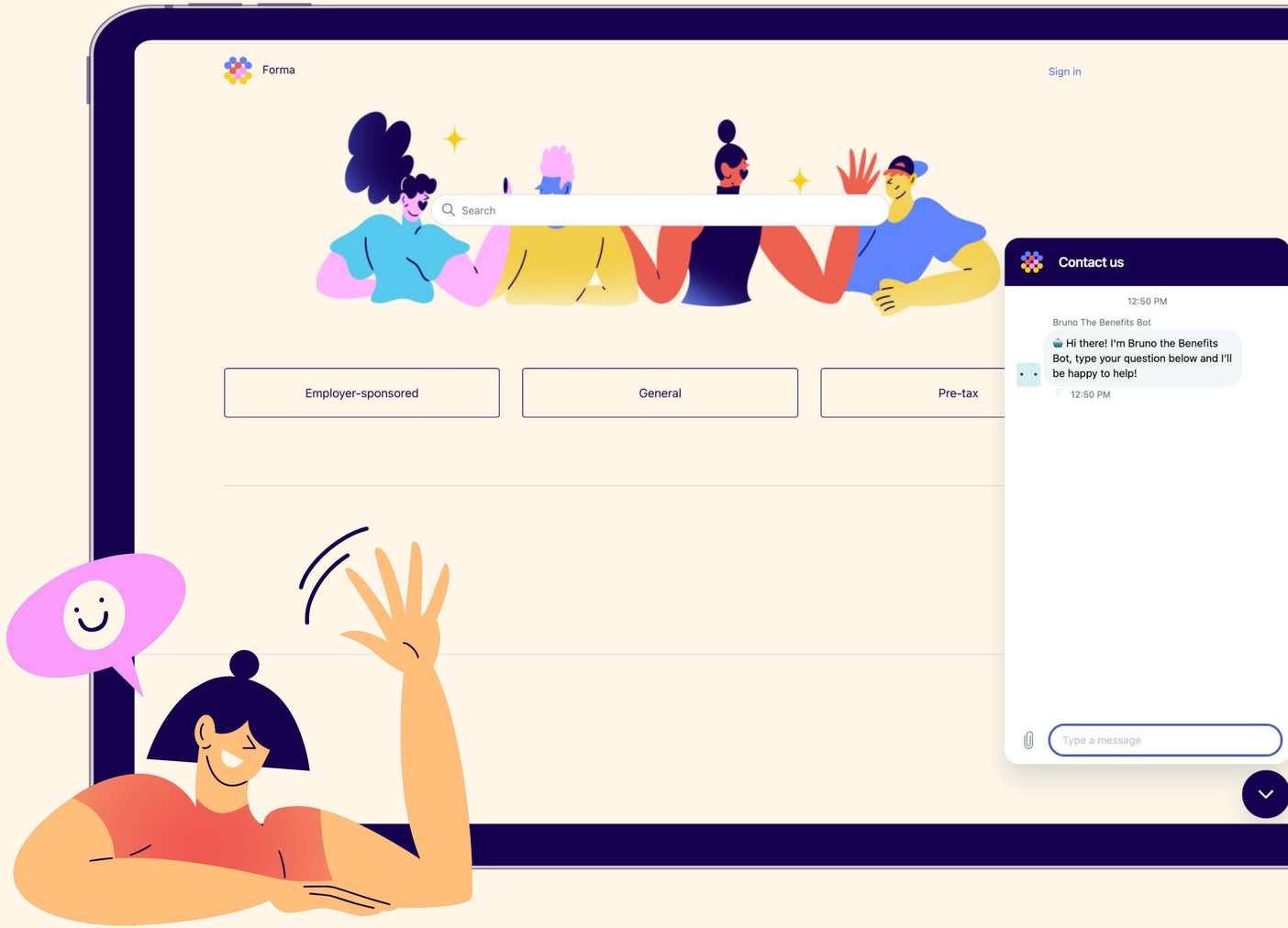
Monday - Friday, 9 am - 8 pm ET



Best practices

Support team (email or message)

Please share as much detail as possible about what help you need. We can provide better answers with more detailed context.



Let’s talk about next steps

1. Pre-tax elections are active! Enroll by **11/14/25** within **Paycom**
2. Activate your Forma account once email is received
3. Begin to use these benefits starting 1/1/2026

Appendix

FSA Glossary

- **Run out Period**
  - The time period you have to submit all expenses to Forma before you lose out on your funds. Generally this is 90 days post plan year end but can vary. Please note, this date does not extend your time period to incur new claims but instead submit claims that were incurred during your plan year
  - Example: If your plan year is 1/1/2026 - 12/31/2026 (and you do not have a grace period), your can only incur claims through 12/31/2026 and must submit all expenses to Forma no later than March 30th 2027 for reimbursement. Any claims not submitted by that date will be lost.
- **Carryover / Rollover**
  - If your employer has a carryover / rollover provision on your Health Care and/or Limited Purpose FSA, you can carryover / rollover up to the IRS carryover / rollover maximum annually after the run out period ends
  - Example: If you contribute $3,050 in 2026, but only spend $2,050 1/1/2026 - 12/31/2026, you can carry over / roll over up to $660 dollars from 2026 to put into your 2027 FSA. All other amounts will be lost since FSA are generally “use it or lose it”.
- **Grace Period**
  - If your employer offers Grace Period on your Healthcare, Limited Purpose and/or Dependent Care FSA, you have an additional 2 ½ months to incur expenses and submit before the run out period ends.
  - Example: If your plan year is 1/1/2026 - 12/31/2026, you have until March 15th 2027 to incur expenses that must be submitted by March 30th 2027 for reimbursement. Any claims not submitted by that date will be lost.

FSA election changes

1. For Healthcare FSAs, you can only change your election if you've had a Qualifying Life Event (QLE)
2. QLEs include:
    - Change in legal marital status
    - Change in number of tax dependents
    - Death of spouse or dependent
3. Go to your Ben-Admin system to make election changes

Strategic Funding Source Inc. dba Kapitus & Affiliates Flexible Benefits Plan

Plan Document

Amended & Restated

Effective January 1, 2026

ARTICLE I. Introduction

1.1 Establishment of Plan

Strategic Funding Source Inc. dba Kapitus (Employer) hereby amends and restates the Strategic Funding Source Inc. dba Kapitus & Affiliates Flexible Benefits Plan (Plan) effective January 1, 2026.

This Plan is designed to permit Eligible Employees to make Contributions on a pre-tax basis to a Health FSA Account for reimbursement of certain Medical Care Expenses and to the Premium Payment Benefits for the employee-share of the premium for Premium Payment Benefits coverage, as set forth in the summary plan description (SPD) to the Plan.

1.2 Legal Status

This Plan is intended to qualify as a cafeteria plan under Code §125 and the regulations issued thereunder and shall be interpreted to accomplish that objective.

ARTICLE II. Definitions

2.1 Definitions

Account(s) means the Health FSA Accounts.

Benefits means the Premium Payment Benefits and the Health FSA Benefits.

Benefit Package Option means a qualified benefit under Code §125(f) that is offered under a cafeteria plan. Benefits prohibited under Code §125(f) (such as long-term care insurance and certain Exchange-participating qualified health plans) are not permitted Benefit Package Options.

Change in Status means any of the events described below, as well as any other events included in subsequent changes to Code §125, or regulations or guidance issued thereunder that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under

applicable law and under this Plan:

(a) *Legal Marital Status.* A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

(b) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan;

(d) *Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, or any similar circumstance; and

(e) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code means the Internal Revenue Code of 1986, as amended.

Compensation means the wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election under this Plan; (b) any salary reduction election under any other cafeteria plan; and (c) any compensation reduction under any Code §132(f)(4) plan; but determined after (d) any salary deferral elections under any Code §401(k), 403(b), 408(k), or 457(b) plan or arrangement. Thus, "Compensation" generally means wages or salary paid to an Employee by the Employer, as reported in Box 1 of Form W-2, but adding back any wages or salary forgone by virtue of any election described in (a), (b), or (c) of the preceding sentence.

Component(s) means one or more of the following as set forth in the SPD: the Health FSA Component or the Premium Payment Component.

Contributions means the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured), as calculated under Section 6.2 for Premium Payment Benefits and Section 7.2 for Health FSA Benefits.

Dependent means: (a) for purposes of accident or health coverage (to the extent funded under the Premium Payment Component, and for purposes of the Health FSA Component), (1) a dependent as defined in Code §105(b), (2) any child (as defined in Code §152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year). Notwithstanding the foregoing, the Health FSA Component will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of Dependent.

Dependent Care Expenses has the meaning described in Section 9.3.

Earned Income shall have the meaning given such term in Code §129(e)(2).

Election Form/Salary Reduction Agreement means the actual or deemed paper or electronic form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for any of the following: Premium Payment Benefits and Health FSA Benefits. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions.

Eligible Employee means an Employee eligible to participate in this Plan, as provided in Section 3.1.

Employee means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code §414(n)) or individual classified by the Employer as an independent contractor for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any self-employed individual; (d) any partner in a partnership; and (e) any more-than-2% shareholder in a Subchapter S corporation. The term Employee does include former Employees for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

Employer means the Employer and any employer in the same controlled group with the Employer that, under Code §414(b), §414(c), or §414(m), is treated as a single employer with the Employer for purposes

of Code §125(g)(4).

Employment Commencement Date means the first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

FMLA means the Family and Medical Leave Act of 1993, as amended.

General-Purpose Health FSA Option has the meaning described in Section 7.3(b).

Grace Period means the period that begins immediately following the close of a Plan Year and ends on the day that is 2 months plus 15 days following the close of that Plan Year.

Health FSA means health flexible spending arrangement, which consists of two options: the General-Purpose Health FSA Option and the Limited (Vision/Dental/Preventive Care) Health FSA Option.

Health FSA Account means the account described in Section 7.5.

Health FSA Benefits has the meaning described in Section 7.1.

Health FSA Component means the component of this Plan described in Article VII.

Health Plan means the Employer's health plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents who may be eligible under the terms of such plan), providing benefits such as major medical (including a High Deductible Health Plan option), dental, and vision. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

High-Deductible Health Plan means the high-deductible health plan Benefit Package Option (if any) offered by the Employer as a Benefit Package Option under the Health Plan that is intended to qualify as a high-deductible health plan under Code §223(c)(2), as described in materials provided separately by the Employer.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

HMO means the health maintenance organization Benefit Package Option (if any) under the Health Plan.

Limited (Vision/Dental/Preventive Care) Health FSA Option has the meaning described in Section 7.3(b).

Medical Care Expenses has the meaning described in Section 7.3.

Open Enrollment Period with respect to a Plan Year means the period preceding the Plan Year in which

Eligible Employees may change elections, as communicated to Employees by the Employer.

Participant means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include (a) those who elect one or more of the Premium Payment Benefits, Health FSA Benefits, and Salary Reductions to pay for such Benefits.

Period of Coverage means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.2.

Plan means the Plan as set forth herein and as amended from time to time.

Plan Year means the Plan Year, except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

Plan Administrator means the Employer.

PPO means the preferred provider organization Benefit Package Option (if any) under the Health Plan.

Premium Payment Benefits means the Premium Payment Benefits that are paid for on a pre-tax Salary Reduction basis as described in Section 6.1.

Premium Payment Component means the component of this Plan described in Article VI.

QMCSO means a qualified medical child support order, as defined in ERISA §609(a).

Qualifying Individual means (a) a tax dependent of the Participant as defined in Code §152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code §152(a)(1); (b) a tax dependent of the Participant as defined in Code §152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or (c) a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year. Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Code §21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code §152(e)) and shall not be treated as a Qualifying Individual with respect to the noncustodial parent.

Run-Out Period means the deadline for a Participant to submit claims for Health FSA incurred during the Plan Year or associated Grace Period (if any), as set forth in the SPD.

Salary Reduction means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits, as permitted for the applicable component, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pre-tax basis).

Spouse means an individual who is treated as a spouse for federal tax purposes.

Student means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.

ARTICLE III. Eligibility and Participation

3.1 Eligibility to Participate

An individual is eligible to participate in this Plan if the individual: (a) is an Employee; and (b) is eligible for the Health Plan (whether or not coverage under such plan has been elected). Eligibility for Health Plan Premium Payment Benefits shall also be subject to the additional requirements, if any, specified in the Health Plan.

3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

(a) the termination of this Plan; or

(b) the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage certain Employees may continue eligibility for certain periods on the terms and subject to the restrictions described in Section 6.4 for Insurance Benefits and Section 7.8 for Health FSA Benefits.

Termination of participation in this Plan will automatically revoke the Participant's elections. The Health Plan benefits will terminate as of the date(s) specified in the Health Plan. Reimbursements from the Health FSA after termination of participation will be made pursuant to Section 7.8 for Health FSA Benefits.

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such

individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.1. Notwithstanding the above, an election to participate in the Premium Payment Component will be reinstated only to the extent that coverage under the Health Plan is reinstated. If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason (other than for termination of employment), including (but not limited to) a reduction of hours, and then becomes an Eligible Employee again, the Employee must complete the waiting period described in Section 3.1 before again becoming eligible to participate in the Plan.

3.4 FMLA Leaves of Absence

(a) *Health Benefits.* Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Health Plan benefits and Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the Contributions.

An Employer may require Participants to continue all Health Plan benefits and Health FSA Benefits coverage while they are on paid leave, provided that Participants on non-FMLA paid leave are required to continue such coverage. If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (e.g., on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her Health Plan Benefits and Health FSA Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contributions in one of the following ways:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or
- under another arrangement agreed upon between the Participant and the Plan Administrator

(e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If the Employer requires all Participants to continue Health Plan benefits and Health FSA Benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required Contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant.

If a Participant's Health Plan benefits or Health FSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Health Plan benefits or Health FSA Benefits, as applicable, upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose Health Plan benefits or Health FSA Benefits coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage. Notwithstanding the preceding sentence, with regard to Health FSA Benefits a Participant whose coverage ceased will be permitted to elect whether to be reinstated in the Health FSA Benefits at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro rata for the period of FMLA leave, then the amount withheld from a Participant's Compensation on a per-pay-period basis for the purpose of paying for reinstated Health FSA Benefits will be equal to the amount withheld prior to the period of FMLA leave.

(b) *Non-Health Benefits.* If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits is to be determined by the Employer's policy for providing such Benefits when Participants are on non-FMLA leave, as described in Section 3.5. If such policy permits a Participant to discontinue contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant, or as the Plan Administrator otherwise deems appropriate.

3.5 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 11.3(d) will apply.

ARTICLE IV. Method and Timing of Elections

4.1 Elections When First Eligible

An Employee who first becomes eligible to participate in the Plan midyear may elect to commence participation in one or more Benefits on the first day of the month after the eligibility requirements have been satisfied, provided that an Election Form/Salary Reduction Agreement is submitted to the Plan Administrator before the first day of the month in which participation will commence. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a midyear election change, as described under Section 11.3. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the Health Plan.

4.2 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide a paper or electronic Election Form/Salary Reduction Agreement to each Employee who is eligible to participate in this Plan. The Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the various Components of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period, and it shall become effective on the first day of the next Plan Year. If an Eligible Employee fails to return the Election Form/Salary Reduction Agreement during the Open Enrollment Period, then the Employee may not elect any Benefits under this Plan until the next Open Enrollment Period, unless an event occurs that would justify a midyear election change, as described under Section 11.3.

4.3 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the time period described in Sections 4.1 and 4.2, then the Employee may not elect any Benefits under the Plan (a) until

the next Open Enrollment Period; or (b) until an event occurs that would justify a midyear election change, as described under Section 11.3 or 11.4.

4.4 Irrevocability of Elections

Unless an exception applies (as described in Article XI), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

ARTICLE V. Benefits Offered and Method of Funding

5.1 Benefits Offered

When first eligible or during the Open Enrollment Period as described under Article IV, Participants will be given the opportunity to elect one or more of the following Benefits, as set forth in the SPD:

(a) Premium Payment Benefits, as described in Article VI;

(b) Health FSA Benefits, as described in Article VII.

HSA Benefits cannot be elected with Health FSA Benefits unless the Limited (Vision/Dental/Preventive Care) Health FSA Option is selected. In addition, a Participant who elects the High-Deductible Health Plan option may be treated as automatically enrolled in the limited (Vision/Dental/Preventive Care) Health FSA Option for that Plan Year, and unused amounts remaining in the Participant's General-Purpose Health FSA at the end of the preceding Plan Year that are available for carryover as provided in Article VII, if any, will be automatically carried over to that Limited (Vision/Dental/Preventive Care) Health FSA.

In no event shall Benefits under the Plan be provided in the form of deferred compensation. Notwithstanding the foregoing, Health FSA carryovers are permitted as provided in Article VII. In addition, as set forth in the SPD, amounts remaining in a Participant's Health FSA Account at the end of a Plan Year can be used to reimburse the Participant for Dependent Care Expenses or Medicare Care Expenses that are incurred during the Grace Period immediately following the close of that Plan Year as provided in Article IX.

5.2 Employer and Participant Contributions

(a) *Employer Contributions.* For Participants who elect Health Plan benefits described in Article VI, the Employer may contribute a portion of the Contributions.

(b) *Participant Contributions.* Participants who elect any of the Health Plan benefits described in Article VI may pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement. Participants who elect Health FSA Benefits must

pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement.

5.3 Using Salary Reductions to Make Contributions

(a) *Salary Reductions per Pay Period.* The Salary Reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to (1) the annual Contributions for such Benefits (as described in Section 6.2 for Premium Payment Benefits, Section 7.2 for Health FSA Benefits), divided by the number of pay periods in the Period of Coverage; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage in reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate). If a Participant increases his or her election under the Health FSA Component to the extent permitted under Section 11.3, the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to (1) the new reimbursement limit elected pursuant to Section 11.3, less the Salary Reductions made prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage of reducible Compensation, amounts withheld and the benefits to which Salary Reductions are applied may fluctuate).

(b) *Considered Employer Contributions for Certain Purposes.* Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Premium Payment Benefits and Health FSA Benefits, for the purposes of this Plan and the Code, are considered to be Employer contributions.

(c) *Salary Reduction Balance Upon Termination of Coverage.* If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required Contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

5.4 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against,

right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf. The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected (a) as Employer and Participant Contributions for Premium Payment Benefits, as described in Section 6.2; and (b) as described under Section 7.4(b) for Health FSA Benefits.

ARTICLE VI. Premium Payment Component

6.1 Benefits

The Premium Payment Component offers the ability to make contributions for coverage under the Health Plan on a pre-tax basis. Notwithstanding any other provision in this Plan, the Health Plan benefits are subject to the terms and conditions of the Health Plan, and no changes can be made with respect to such Health Plan benefits under this Plan (such as midyear changes in election) if such changes are not permitted under the applicable component of the Health Plan. An Eligible Employee can elect to make pre-tax contributions under the Premium Payment Component by electing to pay for his or her share of the Contributions for Health Plan Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article XI), such election is irrevocable for the duration of the Period of Coverage to which it relates.

6.2 Contributions for Cost of Coverage

The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged by the insurance carrier.

6.3 Benefits Provided Under the Health Plan

Health Plan benefits will be provided by the Health Plan, not this Plan. The types and amounts of Health Plan benefits, the requirements for participating in the Health Plan, and the other terms and conditions of coverage and benefits of the Health Plan are set forth in the Health Plan. All claims to receive benefits under the Health Plan shall be subject to and governed by the terms and conditions of the Health Plan and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.4 Health Plan Benefits Under COBRA

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant

and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Health Plan because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health Plan the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Contributions for COBRA coverage for Health Plan benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Health Plan benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

ARTICLE VII. Health FSA Component

7.1 Health FSA Benefits

An Eligible Employee can elect to participate in the Health FSA Component by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses under one of the Health FSA coverage options described in Section 7.3(b) (Health FSA Benefits); and (b) to pay the Contribution for such Health FSA Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article XI), any such election is irrevocable for the duration of the Period of Coverage to which it relates. Notwithstanding any other provision of this Plan, an Eligible Employee shall not be eligible for the Health FSA Component unless he or she is also eligible for the Health Plan.

7.2 Contributions for Cost of Coverage of Health FSA Benefits

The annual Contribution for a Participant's Health FSA Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 7.4(b).

7.3 Eligible Medical Care Expenses for Health FSA

Under the Health FSA Component, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which an election is in force, or for which Health FSA Benefits are otherwise available as a result of a carryover as provided in Section 7.4. In addition, certain individuals

may receive reimbursement for Medical Care Expenses incurred during the Grace Period immediately following the close of a Plan Year from amounts remaining in their Health FSA Accounts for that Plan Year in accordance with Section 7.4(g).

(a) *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished and not when the Participant is formally billed for, is charged for, or pays for the medical care.

(b) *Medical Care Expenses.* "Medical Care Expenses" will vary depending on which Health FSA coverage option the Participant has elected. HSA Benefits cannot be elected with Health FSA Benefits unless the Limited (Vision/Dental/Preventive Care) Health FSA Option is selected. In addition, a Participant who elects the High-Deductible Health Plan option may treated as automatically enrolled in the Limited (Vision/Dental/Preventive Care) Health FSA Option for that Plan Year, and unused amounts remaining in the Participant's General-Purpose Health FSA at the end of the preceding Plan Year that are available for carryover as provided in Section 7.4, if any, will be automatically carried over to that Limited (Vision/Dental/Preventive Care) Health FSA.

- *General-Purpose Health FSA Option.* For purposes of this Option, Medical Care Expenses means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code §213(d) (including expenses for menstrual care products as defined in Code §223(d)(2)(D)), but only to the extent that the expense has not been reimbursed through insurance or otherwise. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Health Plan imposes copayment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Medical Care Expense if it otherwise meets the requirements of this Article VII. Notwithstanding the foregoing, the term Medical Care Expenses does not include:

  (1) premium payments for other health coverage, including but not limited to health insurance premiums for any other plan (whether or not sponsored by the Employer); or

  (2) cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease (for this purpose, "cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease).

The Plan Administrator may promulgate procedures regarding the eligibility of various expenses for reimbursement as Medical Care Expenses and may limit reimbursement of expenses described in such

procedures.

- *Limited (Vision/Dental/Preventive Care)Health FSA Option.* For purposes of this Option, Medical Care Expenses means expenses incurred by a Participant or his or her Spouse or Dependents for medical care as defined in Code §213(d) and as further described under the General Purpose Health FSA Option-provided, however, that such expenses are for vision care, dental care, or preventive care (as defined in Code §223(c)) only.

7.4 Maximum Benefits for Health FSA

(a) *Maximum Reimbursement Available; Uniform Coverage.* The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage and increased by any carryovers as provided in subsection (f) below) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA Account pursuant to Section 7.5. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after participation in this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.8. Payment shall be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective (or for which carryovers are available as provided in subsection (f), or during a Grace Period if applicable under subsection (g) below), provided that the other requirements of this Article VII have been satisfied.

(b) *Maximum Dollar Limit.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $3,400, as adjusted in subsequent years for inflation, subject to Sections 7.4(c) and 7.5(c). Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.

(c) *Changes; No Proration.* The maximum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document, provided that the maximum dollar limit shall not exceed the maximum amount permitted under Code §125(i). If a Participant enters the Health FSA Component midyear or wishes to increase his or her election midyear as permitted under Section 11.3, then there will be no proration rule-i.e., the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable. Notwithstanding the foregoing, the Plan Administrator may limit the elections of a Participant who is terminated and rehired during the

same Plan Year to the extent necessary to comply with the requirements of Code §125(i).

(d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article XI (other than under Section 11.3(c) for FMLA leave) that increases contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the contributions (if any) made by the Participant as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Health FSA Account, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 11.3(c) for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

(e) *Monthly Limits on Reimbursing OTC Drugs.* Only reasonable quantities of over-the-counter (OTC) drugs or medicines of the same kind may be reimbursed from a Participant's Health FSA Account in a single calendar month (even assuming that the drug otherwise meets the requirements of this Article VII and is for medical care under Code §213(d)); stockpiling is not permitted.

(f) *Carryovers.* As set forth in in the SPD and notwithstanding any other provision of the Plan to the contrary, unused amounts of up to $680 (as adjusted for inflation in subsequent years) remaining in a Participant's Health FSA Account at the end of a Plan Year can be carried over and used to reimburse the Participant for Medical Care Expenses that are incurred during the next Plan Year, subject to the following conditions:

(1) The maximum carryover amount may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document, provided that the maximum carryover amount shall not exceed 20% of the maximum amount permitted under Code §125(i). Carryover amounts may not be cashed out or converted to any other taxable or nontaxable benefit, and will not count toward the maximum dollar limit under subsections (b) and (c) above.

(2) A Participant who is otherwise eligible for the Health FSA for a Plan Year but does not make a Health FSA election for that Plan Year may use any carryovers from the preceding Plan Year for Medical Care Expenses incurred in the current or preceding Plan Year (as further provided herein). However, an Employee or other individual must be a participant in the Health FSA as of the last day of a Plan Year in order to carry over unused amounts to the next Plan Year.

Termination of employment and cessation of eligibility will result in a loss of carryover eligibility unless a COBRA election is made (see Section 7.8).

(3) A Participant who elects the High-Deductible Health Plan option for a Plan Year may be treated as automatically enrolled in the Limited (Vision/Dental/Preventive Care) Health FSA Option for that Plan Year, and unused amounts remaining in the Participant's General-Purpose Health FSA at the end of the preceding Plan Year that are available for carryover, if any, will be automatically carried over to that Limited (Vision/Dental/Preventive Care) Health FSA. However, the Participant may continue to submit claims for general-purpose Medical Care Expenses incurred during the preceding Plan Year until the end of the Run-Out Period, to be reimbursed from the Participant's available General-Purpose Health FSA amounts for the preceding Plan Year. In addition, a Participant may elect prior to the beginning of a Plan Year to waive the carryover from the preceding Plan Year in accordance with procedures established by the Plan Administrator. A Participant who waives the carryover may continue to submit claims for Medical Care Expenses incurred during the preceding Plan Year until the end of the Run-Out Period, to be reimbursed from the Participant's available Health FSA amounts.

(4) Medical Care Expenses incurred during a Plan Year will be reimbursed first from a Participant's unused amounts credited for that Plan Year and then from amounts carried over from the preceding Plan Year. Carryovers that are used to reimburse a current Plan Year expense will reduce the amount available to pay the Participant's preceding Plan Year expenses, cannot exceed the maximum carryover amount, and will count against the maximum carryover amount.

(5) If unused Health FSA Amounts remain for a Plan Year after all reimbursements have been made for that Plan Year in excess of the amount that can be carried over under this subsection (f), the Participant will forfeit all rights with respect to those amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 7.6(b).

(g) *Grace Periods; Special Rules for Claims Incurred During a Grace Period.* As set forth in in the SPD and notwithstanding any contrary provision in this Plan and subject to the conditions of Sections 7.4(b), an individual may be reimbursed for Medical Care Expenses incurred during a Grace Period from amounts remaining in his or her Health FSA at the end of the Plan Year to which that Grace Period relates ("Prior Plan Year Heath FSA Amounts") if he or she Is a Participant in the Plan with Health FSA coverage that is in effect on the last day of that Plan Year.

- Prior Plan Year Health FSA Amounts may not be cashed out or converted to any other taxable or nontaxable benefit. For example, Prior Plan Year Health FSA Amounts may not be used to

reimburse Dependent Care Expenses.

- Medical Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with Section 7.7 will be reimbursed first from any available Prior Plan Year Health FSA Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year. An individual's Prior Plan Year Health FSA Amounts will be debited for any reimbursement of Medical Care Expenses incurred during the Grace Period that is made from such Prior Plan Year Health FSA Amounts.

Claims for reimbursement of Medical Care Expenses incurred during a Grace Period must be submitted no later than the end of the Run-Out Period following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year Health FSA Amounts. Any Prior Plan Year Health FSA Amounts that remain after all reimbursements have been made for the Plan Year and its related Grace Period shall not be carried over to reimburse the Participant for expenses incurred in any subsequent period. The Participant will forfeit all rights with respect to these amounts, which will be subject to the Plan's provisions regarding forfeitures in Section 7.6.

7.5 Establishment of Health FSA Account

The Plan Administrator will establish and maintain a Health FSA Account with respect to each Participant for each Plan Year or other Period of Coverage for which the Participant elects to participate in the Health FSA Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 7.6.

(a) *Crediting of Accounts*. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be credited periodically during such period with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account, as well as any carryovers as provided in Section 7.4.

(b) *Debiting of Accounts*. A Participant's Health FSA Account for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred during such period (or for reimbursement of Medical Care Expenses incurred during any Grace Period to which he or she is entitled as provided in Section 7.4(g)).

(c) *Available Amount Not Based on Credited Amount.* As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year or other Period of Coverage (including the Grace Period, if applicable) and increased by any carryovers, if

applicable; it is not based on the amount credited to the Health FSA Account at a particular point in time except as provided in Section 7.4(f) and Section 7.4(g). Thus, a Participant's Health FSA Account may have a negative balance during a Plan Year or other Period of Coverage, but the aggregate amount of reimbursement shall in no event exceed the maximum dollar amount elected by the Participant under this Plan.

7.6 Forfeiture of Health FSA Accounts; Use-or-Lose Rule

(a) *Use-or-Lose Rule.* Except as otherwise provided in Section 7.4(f) (regarding carryovers, if applicable) and Section 7.4(g) (regarding the Grace Period, if applicable), if any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

(b) *Use of Forfeitures.* All forfeitures under this Plan may be used as follows: to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing Health FSA Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; to reduce the cost of administering the Health FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and/or to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any Health FSA Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

7.7 Reimbursement Claims Procedure for Health FSA

(a) *Timing.* Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(b) *Claims Substantiation.* A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than the end of the Run-Out Period following the close of the Plan Year in which the Medical Care Expense was incurred (except that for a Participant who ceases to be eligible to participate, this must be done no later than 90 days after the date that eligibility ceases, as described in Section 7.8) setting forth:

- the person(s) on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the Expenses so incurred;
- the amount of the requested reimbursement;
- a statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and
- other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, documentation that a medicine or drug was prescribed, or a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and showing the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request. If the Health FSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Section 7.11 and applicable IRS guidance regarding electronic payment card programs.

(c) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article XII.

(d) *Claims Ordering; No Reprocessing.* All claims for reimbursement under the Health FSA Component will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized solely for the purpose of paying it (or treating it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

7.8 Reimbursements From Health FSA After Termination of Participation

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions and election to participate will terminate. Except as otherwise provided in this Section 7.8, the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However,

such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be eligible, provided that the Participant (or the Participant's estate) files a claim within 90 days after the date that the Participant ceases to be a Participant.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under the Health FSA Component because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA) shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health FSA Component the day before the qualifying event for the periods prescribed by COBRA. Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 7.5, they have a positive Health FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the Health FSA Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year, except that qualified beneficiaries who continue coverage through the end of the Plan Year may carry over up to the maximum carryover amount of unused Health FSA amounts remaining at the end of such Plan Year in accordance with the Plan's provisions regarding Health FSA carryovers (see Section 7.4). Such continuation coverage shall be subject to all conditions and limitations under COBRA, except that it shall not be terminated early for after-acquired group health coverage or Medicare entitlement.

Contributions for coverage for Health FSA Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction of hours or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Health FSA Benefits shall be paid on an after-tax basis (unless permitted otherwise by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

7.9 Named Fiduciary for Health FSA

The Employer is the named fiduciary for the Health FSA Component for purposes of ERISA §402(a).

7.10 Coordination of Benefits With HSA

Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses for which Participants have not been previously reimbursed and will not seek reimbursement elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan. Notwithstanding the foregoing, however, in the event that an expense is eligible for reimbursement under both the Health FSA and the HSA, the Participant may choose to seek reimbursement from either the health FSA or the HSA, but not both.

7.11 Electronic Payment Cards

If the Employer allows the Health FSA to be accessed by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Participants will be required to comply with substantiation procedures established by the Plan Administrator in accordance with applicable IRS guidance regarding electronic payment card programs. In addition, the following provisions shall apply:

(a) *Initial and Periodic Certification.* Before receiving an electronic payment card, a Participant must certify that he or she will only use the card to pay for Medical Care Expenses, will not use the card for expenses that have already been reimbursed, will not seek reimbursement under any other health plan for expenses paid for with the card, and will acquire and keep sufficient documentation (see subsection (d) below) for expenses paid with the card. The Participant must also agree to abide by any other the terms and conditions of the card program as set forth herein and in any cardholder agreement issued in conjunction with the card, including but not limited to payment of any fees for participation in the card program and the Plan's right to recoup improper card payments by withholding amounts from Compensation and offsetting against other Health FSA claims. The Participant must reaffirm these agreements during each subsequent Open Enrollment Period in order for the card to remain activated. In addition, these agreements are reaffirmed each time the Participant uses the card. Failure to abide by these agreements may result in deactivation of the card.

(b) *Deactivation of Card.* A Participant's card will be deactivated when participation in the Health FSA ceases or at other times as set forth herein (e.g., for failure to comply with the Plan's substantiation and recoupment procedures). A Participant whose card has been deactivated must request reimbursement for Medical Care Expenses through other methods (e.g., by submitting paper claims).

(c) *Merchants; Card Use.* Card use is limited to eligible merchants as provided in applicable IRS

guidance and as further identified by the Plan Administrator or its designee. The card's debit balance (or credit limit, as applicable) must be limited to the amount of the Participant's available reimbursement as described in Section 7.4. Each time the card is swiped, the Participant certifies to the Plan that the expense for which payment under the Health FSA is being made is a Medical Care Expense that has not already been reimbursed from another source and that reimbursement for the expense will not be sought from another source. Use of a card to pay for a service or product is not considered to be a claim for benefits under the Plan; a claim does not arise until a paper or electronic reimbursement request is submitted.

(d) *Documentation.* For each expense that is paid with the card, the Participant must obtain and retain a bill, invoice, or other statement from the merchant describing the service or product, the date of the service or sale, and the amount of the expense. The documentation must be retained until the close of the Plan Year following the Plan Year in which the card transaction occurred. If the Participant is asked to provide the documentation to the Plan, he or she must do so within the period specified in the request. A Participant who is unable to provide adequate or timely substantiation upon request from the Plan must repay the Plan for the unsubstantiated expense. In addition, the Participant's card may be deactivated.

(e) *Correction of Improper Payments.* Participants must repay the Plan for any improper payments that are made with their cards. Improper payments may be recouped in accordance with applicable IRS guidance. If the Plan is unable to recoup an improper payment, the Employer will treat the payment as it would treat any other business indebtedness. If the debt is not collected and the Employer forgives the indebtedness, the payment will be treated as wages in the year in which the indebtedness was forgiven.

ARTICLE VIII. HIPAA Provisions for Health FSA

8.1 General

As a HIPAA Health Plan, the Health FSA shall comply with the standards for privacy of protected health information as set forth in the Privacy Rule, the security standards for the protection of Electronic PHI as set forth in the Security Rule, and the notification requirements for Breaches of Unsecured PHI under the Breach Notification Rule.

8.2 Definitions

For purposes of this Article, the following definitions shall apply:

(a) "Breach" shall mean the acquisition, access, use, or disclosure of an individual's PHI in a manner not permitted under the Privacy Rule. A Breach shall be presumed unless the Plan

determines there is a low probability that the PHI has been compromised. A Breach does not include: (1) an unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access, or use was in good faith and within the scope of authority and does not result in a further impermissible use or disclosure; (2) an inadvertent disclosure by a person who is authorized to access PHI to another person authorized to access PHI at the same covered entity or business associate or organized health care arrangement, and the information received is not further used or disclosed in a manner not permitted under the Privacy Rule; or (3) a disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(b) "Breach Notification Rule" means the regulations issued under HIPAA set forth in subpart D of 45 CFR Part 164.

(c) "Electronic Protected Health Information" or "Electronic PHI" means PHI that is transmitted by or maintained in electronic media.

(d) "Health Care Operations" is as defined under 45 CFR §164.501.

(e) "HIPAA Health Plan," as defined under 45 CFR §160.103, means an individual or group plan that provides, or pays the cost of, medical care, and includes those plans and arrangements listed in 45 CFR §160.103.

(f) "Payment" is as defined under 45 CFR §164.501, and means activities undertaken by a HIPAA Health Plan to obtain contributions or to determine or fulfill its responsibility for coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care.

(g) "Privacy Policy" means the Employer HIPAA Privacy Policy.

(h) "Privacy Rule" means the regulations issued under HIPAA set forth in subpart E of 45 CFR Part 164.

(i) "Protected Health Information" or "PHI" means individually identifiable health information that (1) relates to the past, present, or future physical or mental condition of a current or former Participant, Spouse, or Dependent, provision of health care to a Participant, Spouse, or Dependent, or payment for such health care; (2) can either identify the Participant, Spouse, or Dependent, or there is a reasonable basis to believe the information can be used to identify the Participant, Spouse, or Dependent; and (3) is received or created by or on behalf of the Health FSA.

(j) "Responsible Employee" means an employee (including a contract, temporary, or leased employee) of the Health FSA or of the Employer whose duties (1) require that the employee have access to PHI for purposes of Payment or Health Care Operations; or (2) make it likely that the

employee will receive or have access to PHI. Persons designated as Responsible Employees are described in Section 10.3.

(k) "Security Incident," as defined under 45 CFR §164.304, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(l) "Security Rule" means the regulations issued under HIPAA set forth in subpart C of 45 CFR Part 164.

8.3 Responsible Employees

Only Responsible Employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of a Health FSA. The use or disclosure of PHI or Electronic PHI by Responsible Employees shall be restricted to the Health FSA administration functions that the Employer performs on behalf of a Health FSA pursuant to Section 10.4.

(a) Employer employees who perform the following functions on behalf of the Health FSA are Responsible Employees: (1) claims determination and processing functions; (2) Health FSA vendor relations functions; (3) benefits education and information functions; (4) Health FSA administration activities; (5) legal department activities; (6) Health FSA compliance activities; (7) information systems support activities; (8) internal audit functions; and (9) human resources functions.

(b) In addition to those individuals described in subsection (a), the Health FSA HIPAA privacy official and security official, and Employer employees to whom the Health FSA HIPAA privacy official and security official have delegated any of the following responsibilities, shall also be Responsible Employees: (1) implementation, interpretation, and amendment of the Privacy Policy; (2) Privacy Rule, Breach Notification Rule, or Security Rule training for Employer employees; (3) investigation of and response to complaints by Participants, Spouses, Dependents, and/or employees; (4) preparation, maintenance, and distribution of the health FSA's privacy notice; (5) response to requests by Participants, Spouses, or Dependents to inspect or copy PHI; (6) response to requests by Participants, Spouses, or Dependents to restrict the use or disclosure of their PHI; (7) response to requests by Participants, Spouses, or Dependents to receive communications of their PHI by alternate means or in an alternate manner; (8) amendment and response to requests to amend the PHI of Participants, Spouses, or Dependents; (9) response to requests by Participants, Spouses, or Dependents for an accounting of disclosures of their PHI; (10) response to requests for information by the Department of Health and Human Services; (11) approval of disclosures to law enforcement or to the military for government purposes; (12) maintenance of

records and other documentation required by the Privacy Rule, Breach Notification Rule, or Security Rule; (13) negotiation of Privacy Rule, Breach Notification Rule, and Security Rule provisions and/or reasonable security provisions into contracts with third-party service providers; (14) maintenance of Health FSA PHI or Electronic PHI security documentation; or (15) approval of access to Electronic PHI by Participants, Spouses, or Dependents.

8.4 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 the Health FSA, consistent with the Privacy Policy. This includes:

(a) uses and disclosures for the Health FSA'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 CFR §160.103, for the health care provider's treatment activities;

(d) disclosures to the Employer, acting in its role as Plan sponsor, of (1) summary health information for purposes of obtaining health insurance coverage or premium bids for HIPAA Health Plans or for making decisions to modify, amend, or terminate a HIPAA Health Plan; or (2) enrollment or disenrollment information;

(e) disclosures of a Participant's, Spouse's, or Dependent's PHI to the Participant or the Dependent or his or her personal representative, as defined under 45 CFR §164.502(g);

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

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

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

(i) disclosures to the Secretary of Health and Human Services to demonstrate the Health FSA's compliance with the Privacy Rule, Security Rule, or Breach Notification Rule;

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

(k) 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;

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

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

(n) uses and disclosures pursuant to the Participant's authorization that satisfies the requirements of 45 CFR §164.508.

8.5 Prohibited Uses and Disclosures

Notwithstanding anything in the Plan to the contrary, use or disclosure of Protected Health Information is prohibited in the following situations.

(a) *Genetic Information*. Use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not be a permitted use or disclosure. The term "underwriting purposes" includes determining eligibility or benefits, computation of premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.

(b) *Employment-Related Actions*. Use or disclosure of Protected Health Information for the purpose of employment-related actions or decisions shall not be a permitted use or disclosure.

(c) *Other Benefits.* Use or disclosure of Protected Health Information in connection with any other benefit or employee benefit plan of the Employer, except as expressly permitted in Section 10.4, shall not be a permitted use or disclosure.

8.6 Certification Requirement

The Health FSA shall disclose PHI, including Electronic PHI, to Responsible Employees only upon receipt of a certification by the Employer that the Employer 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 take reasonable steps to ensure that any agents to whom the Employer provides PHI or Electronic PHI received from the Health FSA agree: (1) to the same restrictions and conditions that apply to the Employer with respect to such PHI; and (2) to implement reasonable and appropriate security measures to protect such Electronic PHI;

(c) 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 Employer other than another Health Plan;

(d) to report to the Health FSA any use or disclosure of PHI, including Electronic PHI, that is inconsistent with the uses or disclosures described in Section 10.4, or any Security Incident, of which the Employer becomes aware;

(e) to make available PHI for inspection and copying in accordance with 45 CFR §164.524;

(f) to make available PHI for amendment, and to incorporate any amendments to PHI, in accordance with 45 CFR §164.526;

(g) to make available PHI required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

(h) to make its internal practices, books, and records relating to the use and disclosure of PHI and Electronic PHI, received on behalf of the Health FSA, available to the Secretary of Health and Human Services for purposes of determining compliance by the Health FSA with the Privacy Rule, the Breach Notification Rule, or the Security Rule;

(i) if feasible, to return or destroy all PHI and Electronic PHI received from the Health FSA that the Employer still maintains in any form and retain no copies of such PHI and Electronic 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 and Electronic PHI infeasible;

(j) to take reasonable steps to ensure that there is adequate separation between the Health FSA and the Employer's activities in its role as Health FSA sponsor and employer, and that such adequate separation is supported by reasonable and appropriate security measures; and

(k) to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the FSA.

8.7 Mitigation

In the event of noncompliance with any of the provisions set forth in this Article:

(a) The HIPAA privacy official or security official, as appropriate, shall address any complaint promptly and confidentially. The HIPAA privacy official or security official, as appropriate, first will investigate the complaint and document the investigation efforts and findings.

(b) If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Article, the HIPAA privacy official and/or the security official, as appropriate, shall 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 Employer employee is found to have violated the Privacy Policy and/or policy developed under the Security Rule, such personnel shall be subject to disciplinary action up to and including termination.

8.8 Breach Notification

Following the discovery of a Breach of unsecured PHI, the Health FSA shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 CFR §164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 CFR §164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the Health FSA shall notify the media in accordance with 45 CFR §164.406. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

ARTICLE IX. Irrevocability of Elections; Exceptions

9.1 Irrevocability of Elections

Except as described in this Article XI, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

(a) participation in this Plan;

(b) Salary Reduction amounts; or

(c) election of particular Benefit Package Options (including the various Health FSA Options).

However, as described further in Section 11.4, an election to make a Contribution to an HSA can be changed at any time on a prospective basis.

9.2 Procedure for Making New Election If Exception to Irrevocability Applies

(a) *Timeframe for Making New Election.* A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period under Section 3.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 11.3 (or within 60 days of the occurrence of an event described in Section 11.3(e)(3) or (4)), as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event. Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under the Health Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) *Effective Date of New Election.* Elections made pursuant to this Section 11.2 shall be effective

for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 11.3(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change request was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that any replacement coverage commences later).

(c) *Effect of New Election Upon Amount of Benefits.* For the effect of a changed election upon the maximum benefits under the Health FSA, see Sections 7.4 and 9.4.

9.3 Events Permitting Exception to Irrevocability Rule for All Benefits

A Participant may change an election as described below upon the occurrence of the stated events for the applicable component of this Plan:

(a) *Open Enrollment Period (Applies to Premium Payment, Health FSA).* A Participant may change an election during the Open Enrollment Period in accordance with Section 3.2.

(b) *Termination of Employment (Applies to Premium Payment and Health FSA Benefits).* A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.3 and 3.4, as applicable.

(c) *Leaves of Absence (Applies to Premium Payment and Health FSA Benefits).* A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.

(d) *Change in Status (Applies to Premium Payment Benefits and Health FSA Benefits as Limited Below).* A Participant may change his or her election under the Plan upon the occurrence of a Change in Status, but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

Election changes may not be made to reduce Health FSA coverage during a Period of Coverage; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of a Spouse, divorce, legal separation, or

annulment; death of a Dependent; change in employment status such that the Participant becomes ineligible for Health FSA coverage; or a Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage. Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(1) *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For a Change in Status involving a Participant's divorce, annulment, or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan because of a reduction of hours or because the Participant's Dependent ceases to satisfy the eligibility requirements for coverage (and the Participant remains a Participant under this Plan in accordance with Section 3.2), then the Participant may increase his or her election to pay for such coverage.

(2) *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(e) *HIPAA Special Enrollment Rights (Applies Only to Premium Payment Benefits for the Health Plan).* If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code §9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment rights. As required by HIPAA, a special enrollment right will arise in the following circumstances:

(1) a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because: (1) the coverage was provided under COBRA, and the COBRA coverage was exhausted; or (2) the coverage was non-COBRA coverage, and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated;

(2) a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption;

(3) the Participant's or Dependent's coverage under a Medicaid plan or state children's health insurance program is terminated as a result of loss of eligibility for such coverage; or

(4) the Participant or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

For purposes of Section 11.3(e)(1), the term "loss of eligibility" includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit package is available to the individual; a situation in which an individual incurs a claim that would meet or

exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) *Certain Judgments, Decrees, and Orders (Applies to Premium Payment and Health FSA Benefits).* If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan, and such coverage is actually provided.

(g) *Medicare and Medicaid (Applies to Premium Payment Benefits, to Health FSA Benefits as Limited Below).* If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Health FSA coverage may be canceled (but not reduced). Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Health FSA coverage may commence or increase.

(h) *Change in Cost (Applies to Premium Payment Benefits).* For purposes of this Section 11.3(h), "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, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan 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 Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) *Significant Cost Increases.* If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) (such as the PPO for the Health Plan) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (such as an HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan 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.

(3) *Significant Cost Decreases.* If the Plan Administrator determines that the cost of any Benefit Package Option (such as the PPO for the Health Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in that Benefit Package Option may make a corresponding prospective decrease in their elective contributions (by decreasing Salary Reductions); (b) Participants who are enrolled in another Benefit Package Option (such as an HMO, but not the Health FSA) may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost (such as the PPO for the Health Plan); or (c) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan 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.

(i) *Change in Coverage (Applies to Premium Payment Benefits).*

The definition of "similar coverage" under Section 11.3(h) applies also to this Section 11.3(i).

(1) *Significant Curtailment.* If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan 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 Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the copay, or the out-of-pocket cost-sharing limit under an accident or health plan, such as the PPO under the Health Plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA). 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 Coverag*e. If the Plan Administrator determines that a Participant's Benefit Package Option (such as the PPO under the Health Plan) coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage (such as the HMO, but not the Health FSA) or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(c) *Definition of Loss of Coverage.* For purposes of this Section 11.3(i)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual

limitation). In addition, the Plan 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 the Benefit Package 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 the PPO for the Health Plan or in an HMO);
- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or
- any other similar fundamental loss of coverage.

(2) *Addition or Significant Improvement of a Benefit Package Option.* If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan 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 Package Option in accordance with prevailing IRS guidance.

(3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or 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 children's health insurance program under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code §7701(a)(40)), 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 Package Option(s).

(4) *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 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 Period of Coverage 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 his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan 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.

(j) *Reduction of Hours (Applies Only to Premium Payment Benefits for the Health Plan).* A Participant who was reasonably expected to average 30 hours of service or more per week and experiences an employment status change such that he or she is reasonably expected to average less than 30 hours of service per week may prospectively revoke his or her election for Health Plan coverage, provided that the Participant certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform for coverage that is effective no later than the first day of the second month following the month that includes the date the Health Plan coverage is revoked.

(k) *Exchange Enrollment (Applies Only to Premium Payment Benefits for the Health Plan).* A Participant who is eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during an Exchange special or annual open enrollment period may prospectively revoke his or her election for Health Plan coverage, provided that the Participant certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of the Health Plan coverage.

A Participant entitled to change an election as described in this Section 11.3 must do so in accordance with the procedures described in Section 11.2.

9.4 Election Modifications Required by Plan Administrator

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having

to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE X. Appeals Procedure

10.1 Procedure If Benefits Are Denied Under This Plan

If a claim for benefits under this Plan is wholly or partially denied, then claims shall be administered in accordance with the claims procedure set forth in the SPD.

10.2 Claims Procedures for Health Plan Benefits

Claims and reimbursement for Health Plan benefits shall be administered in accordance with the claims procedures for the Health Plan benefits, as set forth in the plan documents and/or summary plan description for the Health Plan.

10.3 Claims Deadline

Unless otherwise provided herein or required pursuant to applicable law, a claim for benefits under this Plan must be made within one year after the date the expense was incurred that gives rise to the claim. It is the responsibility of the Employee or his or her designee to make sure this requirement is met.

10.4 Limitations Period for Filing Suit

Unless otherwise provided herein or required pursuant to applicable law, a suit for benefits under this Plan must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedure.

ARTICLE XI. Recordkeeping and Administration

11.1 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

11.2 Powers of the Plan Administrator

The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

11.3 Reliance on Participant, Tables, etc.

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of

direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

11.4 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

11.5 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

11.6 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

11.7 Bonding

The Plan Administrator shall be bonded to the extent required by ERISA.

11.8 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) 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 shall not be assets of the Plan but shall be the property of and be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

11.9 Inability to Locate Payee

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

11.10 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code §125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XI1. General Provisions

12.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Section 7.6 with respect to Health FSA Benefits. Any such fees shall be the responsibility of the Participant; they will not be paid by the Employer.

12.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time.

12.3 Amendment and Termination

The Employer may amend or terminate all or any part of this Plan (including any Component) at any time for any reason by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action.

12.4 Compliance With Code, ERISA, and Other Applicable Laws

It is intended that this Plan meet all applicable requirements of the Code and ERISA and of all regulations issued thereunder. (ERISA applies to the Health Plan and the Health FSA Component) This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict. In addition, the Plan will comply with the requirements of all other applicable laws.

12.5 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

12.6 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

12.7 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

12.8 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

12.9 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

ARTICLE XIII. Execution

IN WITNESS WHEREOF, the below individual has caused this Plan to be executed on behalf of the Employer, effective as of the date set forth above.

Print Name: Lauren Ressa

Title: Director, HR Programs

Signature: DocuSigned by: Lauren Ressa 7040AA2828044D1...

Date: 11/05/2025

Strategic Funding Source Inc. dba Kapitus & Affiliates Flexible Benefits Plan
Summary Plan Description
Amended and Restated
January 1, 2026

Introduction

Strategic Funding Source Inc. dba Kapitus (the Employer) sponsors the Strategic Funding Source Inc. dba Kapitus & Affiliates Flexible Benefits Plan (the Cafeteria Plan) that allows eligible Employees to choose from a menu of different benefits to suit their needs and to pay for those benefits with pre-tax dollars. (Such plans are also known as cafeteria plans.)

This Summary describes the basic features of the Cafeteria Plan, how it operates, and how to get the maximum advantage from it. This Summary does not describe every detail of the Cafeteria Plan. If there is a conflict between the Cafeteria Plan Documents and this Summary, then the Cafeteria Plan Document (including any amendments) will control.

Plan Components Offered

☒ Health Flexible Spending Arrangement (Health FSA) Component
- ☒ Carryover

☒ Premium Payment Component
- ☒ Group Health Insurance
- ☒ Group Dental Insurance
- ☒ Group Vision Insurance

Specific Plan Provisions

General Plan Information

- Plan Name: Strategic Funding Source Inc. dba Kapitus & Affiliates Flexible Benefits Plan
- Effective Date: January 1, 2026
- Plan Year: 1/1/26 - 4/30/26 Initial Short Plan Year
  5/1 - 4/30 Beginning with the 5/1/26 Plan Year

Plan Number

- 501

Plan Sponsor

- Strategic Funding Source Inc. dba Kapitus
  120 West 45th Street, 4th Floor
  New York, NY 10036
  (212) 354-1400
- Federal employer tax identification number (EIN): 01-0855279

Plan Administrator

- Lauren Ressa
  120 West 45th Street, 4th Floor
  New York, NY 10036
  (212) 354-1400

Agent for Service of Legal Process

- Strategic Funding Source Inc. dba Kapitus
  120 West 45th Street, 4th Floor
  New York, NY 10036

Third-Party Administrator Information

- Forma Inc.
  http://www.joinforma.com

Run-Out Period for Health FSA and DCAP

- 90 days after the end of the Plan Year

Plan Eligibility

- Active, full-time employees with an average weekly schedule of 30 hours or more are eligible to participate in the Plan

Plan Waiting Period

- 0 days

Plan Entry Date

- First of month following date of hire

Run-Out Period for Terminated Employees

- 90 days after termination of active coverage

Health FSA Maximum Employee Contribution Limit

- $3,400 for the 2026 plan year
  Note: The maximum contribution limit to the Health FSA will be prorated for a short Plan Year.

  Note: The annual maximum contribution limit to the Health FSA is indexed annually to account for cost-of-living adjustments. The Plan's maximum employee contribution limit in future Plan Years will be the indexed limit announced annually by the IRS.

General Plan Provisions

Q-1. How do employees pay for benefits on a pre-tax basis?

An Employee's election to pay for benefits on a pre-tax basis is made by entering into an Election Form/Salary Reduction Agreement with the Employer. Under that Agreement, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

Q-2. What benefits may be elected under the Cafeteria Plan?

The Cafeteria Plan includes the following components:

- *Health Flexible Spending Arrangement (Health FSA) Component*-permits an Employee to pay for his or her qualifying Medical Care Expenses (defined in Q-22) that are not otherwise reimbursed by insurance with pre-tax dollars. Benefits provided under the Health FSA are called Health FSA Benefits. As described in Q-22, the Health FSA election may be for:
  - General-Purpose Health FSA Coverage
- *Premium Payment Component* -permits an Employee to pay for his or her share of contributions for the Premium Payment Benefits with pre-tax dollars.

  Benefits provided generally under the Premium Payment Component are called Premium Payment Benefits.

For purposes of the Premium Payment Benefits, the terms Spouse and Dependent are defined as provided in the Premium Payment Benefits documents. For purposes of the other benefits, Spouse means a person of the same or opposite sex to whom you are legally married and who is treated as a spouse for federal tax purposes. For purposes of the Health FSA, Dependent means (a) your son, daughter, stepchild, legally adopted child, or eligible foster child who has not attained age 27 as of the end of the calendar year; and (b) your tax dependent under the Code except that an individual's status as a Dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Code's definition. If you have questions about whether an individual qualifies as a spouse or dependent, contract your Plan Administrator.

If you select one or more of the above benefits, you will pay all or some of the contributions; the Employer

may contribute some or no portion of them. The applicable amounts will be described in documents furnished separately to you.

Q-3. Who can participate in the Cafeteria Plan?

Employees who are eligible for the Premium Payment Benefits are eligible to participate in the Cafeteria Plan, provided that the election procedures in Q-5 are followed.

An Employee is an individual whom the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll. Employees do not, however, include (a) leased employees or individuals classified by the Employer as independent contractors, even if such an individual is later reclassified as a common-law employee; (b) individuals who perform services for the Employer but who are paid by a temporary or other employment or staffing agency; or (c) self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

Q-4. What tax savings are possible under the Cafeteria Plan?

You may save both federal income tax and FICA (Social Security) taxes by participating in the Cafeteria Plan. How much an employee actually saves will depend on what family members are covered and the contributions for the coverage, the total family income, and the tax deductions and credits claimed. There may be state tax savings, too.

Q-5. When does participation begin and end in the Cafeteria Plan?

After you satisfy the eligibility requirements described in the Specific Plan Provisions, you become a Participant by completing an individual Election Form/Salary Reduction Agreement. You must complete the Election Form/Salary Reduction Agreement within the time period specified in the enrollment materials. An eligible Employee who fails to complete the Election Form/Salary Reduction Agreement as required will not be able to elect any benefits under the Cafeteria Plan until the next Open Enrollment Period (unless a Change in Election Event occurs, as explained in Q-7).

Employees who participate in the Cafeteria Plan are called "Participants." An Employee continues to participate in the Cafeteria Plan until (a) termination of the Cafeteria Plan; or (b) the date on which the Participant ceases to be an eligible Employee (because of retirement, termination of employment, layoff, reduction of hours, or any other reason). However, for purposes of pre-taxing COBRA coverage for Health Plan Benefits, and Health FSA Benefits, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See Q-12 and Attachment 1 (found at the end of this Summary).

See Q-8, Q-12, and Attachment 2 (found at the end of this Summary) for information about how termination of participation affects your Benefits.

Q-6. What is the Significance of the Open Enrollment Period?

The Open Enrollment Period is the period during which you have an opportunity to participate under the Cafeteria Plan by completing an Election Form/Salary Reduction Agreement. (See Q-5.) You will be notified of the timing and duration of the Open Enrollment Period by the Employer.

Q-7. Can I change my elections under the Cafeteria Plan during the Plan Year?

With the exception of HSA Benefits (for which prospective election changes generally are allowable), you generally cannot change your election to participate in the Cafeteria Plan or vary the salary reduction amounts that you have selected during the Plan Year (known as the irrevocability rule). You can change your elections for benefits and salary reductions during the Open Enrollment Period, but those election changes will apply only for the following Plan Year. During the Plan Year, however, there are several important exceptions to the irrevocability rule. See the various Change in Election Events that are described in Attachment 1 (found at the end of this Summary).

The Plan Administrator may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a key employee or highly compensated individual as defined by the Internal Revenue Code (the Code), if necessary, to prevent the Cafeteria Plan from becoming discriminatory within the meaning of the federal income tax law. If a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator will correct the mistake in the manner and to the extent that it deems administratively possible and otherwise permissible under applicable law. Such action by the Plan Administrator may include withholding any amounts due from your compensation.

Q-8. What happens if my employment ends during the Plan Year, or I lose eligibility for other reasons?

If your employment with the Employer is terminated during the Plan Year, then your active participation in the Cafeteria Plan will cease and you will not be able to make any more contributions to the Cafeteria Plan for Health Plan Benefits, Health FSA Benefits, or DCAP Benefits. The Premium Payment Benefits will terminate as of the date(s) specified in the Premium Payment Plan. See Q-12, Attachment 2 (found at the end of this Summary), and the booklets for the Health Plan for information on your right to continued or converted group health coverage after termination of your employment.

For reimbursement of expenses from the Health FSA Account after termination of employment, see Q-24. For reimbursement of expenses from the DCAP Account after termination of employment, see Q-43.

For purposes of pre-taxing COBRA coverage for Health Plan Benefits and Health FSA Benefits, certain

Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See Q-12 and Attachment 1 (found at the end of this Summary).

If you are rehired within the same Plan Year and are eligible for the Cafeteria Plan, then you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less during the same Plan Year, then your prior elections will be reinstated.

Q-9. Will I pay any administrative costs under the Cafeteria Plan?

No. The cost is paid in part by the use of forfeitures, if any (see Q-26 and Q-45). The rest of the cost of administering the Cafeteria Plan is paid entirely by the Employer.

Q-10. How long will the Cafeteria Plan remain in effect?

Although the Employer expects to maintain the Cafeteria Plan indefinitely, it has the right to amend or terminate all or any part of the Cafeteria Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Cafeteria Plan be amended accordingly.

Q-11. What happens if my claim for benefits is denied?

Premium Payment Benefits. The applicable insurance company will decide your claim in accordance with its claims procedures. If your claim is denied, you may appeal to the insurance company for a review of the denied claim. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). Note that under certain circumstances, you may also have the right to obtain external review (that is, review outside of the plan). For more information about how to file a claim and for details regarding the Premium Payment Benefits Plan insurance companies' claims procedures, consult the claims procedures applicable under that plan or policy, as described in the plan document or summary plan description for the Premium Payment Benefits Plan.

Claims Under the Cafeteria Plan, Health FSA, or DCAP. If a claim for reimbursement under the Health FSA or DCAP Components of the Cafeteria Plan is wholly or partially denied, or you are denied a benefit under the Cafeteria Plan (such as the ability to pay for Health Plan, Health FSA, or DCAP Benefits on a pre-tax basis) due to an issue germane to your coverage under the Cafeteria Plan (for example, a determination of a Change in Status; a "significant" change in contributions charged; or eligibility and participation matters under the Cafeteria Plan document), then the claims procedure described below will apply.

If your claim is denied in whole or in part, you will be notified in writing by the Third-Party Administrator within 30 days after the date the Third-Party Administrator received your claim. (This time period may be

extended for an additional 15 days for matters beyond the control of the Third-Party Administrator, including in cases where a claim is incomplete. The Third-Party Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Third-Party Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will have the effect of suspending the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will set out:

- a specific reason or reasons for the denial;
- the specific Plan provision on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary; and
- appropriate information on the steps to be taken if you wish to appeal the Third-Party Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

Appeals. If your claim under the Cafeteria Plan, Health FSA, or DCAP is denied in whole or part, then you (or your authorized representative) may request review upon written application to the Third-Party Administrator that acts on behalf of the Plan Administrator with respect to appeals. Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Decision on Review. Appeals under the Cafeteria Plan, Health FSA, or DCAP will be reviewed and decided by the Third-Party Administrator or other entity designated in the Plan in a reasonable time not later than 60 days after the Third-Party Administrator receives your request for review. The Third-Party Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If

the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- the specific reason(s) for the decision on review;
- the specific Plan provision(s) on which the decision is based;
- a statement of your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- a statement of your right to bring suit under ERISA §502(a) (where applicable).

Limitations Period for Filing Suit. Unless otherwise provided under the Plan or required pursuant to applicable law, a suit for benefits under the Cafeteria Plan, Health FSA, or DCAP must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Q-12. What is Continuation Coverage, and how does it work?

COBRA. COBRA coverage is a continuation of health coverage that would otherwise end because of a life event known as a "qualifying event." See Attachment 2 (found at the end of this Summary) regarding COBRA coverage under the Health FSA Component, including when it may become available to you and your family and what you need to do to protect the right to receive it. See the booklets for the Health Plan for information about COBRA continuation coverage under those plans. Note also that for purposes of pre-taxing COBRA coverage, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods-see Attachment 1 (found at the end of this Summary).

USERRA. Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the federal Uniformed Services Employment and Reemployment Rights Act (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

Q-13. How will participating in the Cafeteria Plan affect my Social Security and other benefits?

Participating in the Cafeteria Plan will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and

life insurance), which are based on taxable compensation. However, the tax savings that you realize through Cafeteria Plan participation will often more than offset any reduction in other benefits.

Q-14. How do leaves of absence (such as under FMLA) affect my benefits?

FMLA Leaves of Absence. If you go on a qualifying leave under the federal Family and Medical Leave Act (FMLA), then to the extent required by the FMLA your Employer will continue to maintain your Health Plan Benefits and Health FSA Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all Health Plan Benefits and Health FSA Benefits coverage while you are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary-reduction basis).

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your Health Plan Benefits and Health FSA Benefits, the Plan Administrator may permit you to pay your share of the contributions in one of three ways: (a) with after-tax dollars while on leave; (b) with pre-tax dollars to the extent that you receive compensation during the leave, or by prepaying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and vacation days (to prepay in advance, you must make a special election before such compensation normally would be available to you (but note that pre-payments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other arrangements agreed upon by you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your Employer requires all Participants to continue Health Plan Benefits and Health FSA Benefits during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Plan Administrator agree to.

If your Health Plan Benefits or Health FSA Benefits coverage ceases while you are on FMLA leave (e.g., for nonpayment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return

from leave. But despite the preceding sentence, with regard to Health FSA Benefits, if your coverage ceased you will be permitted to elect whether to be reinstated in the Health FSA Benefit at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which you did not pay contributions. If you elect the pro-rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA Benefits will equal the amount withheld before FMLA leave.

If you are commencing or returning from FMLA leave, then your election for non-health benefits (such as DCAP Benefits) will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave (see below). If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

Non-FMLA Leaves of Absence. If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be prepaid before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply (see Attachment 1 found at the end of this Summary).

Premium Payment Component

Q-15. What are Premium Payment Benefits?

As described in Q-1, if you elect Premium Payment Benefits you will be able to pay for your share of contributions for Premium Payment Benefits with pre-tax dollars by entering into an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes. See Q-4.

Q-16. How are my Premium Payment Benefits paid?

As described in Q-1 and in Q-15, if you select Premium Payment Benefits described in Q-15, then you may be required to pay a portion of the contributions. When you complete the Election Form/Salary Reduction Agreement, if you elect to pay for benefits on a pre-tax basis, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then

on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

The Employer may contribute all, some, or no portion of the Premium Payment Benefits that you have selected, as described in documents furnished separately to you.

Health FSA Component

Q-17. What are Health FSA Benefits?

As described in Q-2, a Health FSA permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Medical Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from the Health Plan).

As described in Q-1, if you elect Health FSA Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Medical Care Expenses by entering into an Election Form/Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes. See Q-4 for an example dealing with pre-tax payment of Health Plan contributions.

Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses not reimbursed elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

Q-18. What is my Health FSA Account?

If you elect Health FSA Benefits, then an account called a Health FSA Account will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you have paid for such benefits during the Plan Year. Your Health FSA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest.

A Health FSA election may be for only one of the following:

(a) General-Purpose Health FSA Coverage

Note: If you elect Health FSA Benefits, you cannot otherwise make contributions to an HSA. If you elect the General-Purpose Health FSA Coverage Option, your Spouse (if you are married) and your Dependents will also be ineligible to make HSA contributions. Also see Q-20 regarding the impact of carryovers on

HSA eligibility.

Q-19. What are the maximum and minimum Health FSA Benefits that I may elect, and how are these benefits paid for?

You may choose any amount of Medical Care Expenses reimbursement that you desire under the Health FSA, subject to a minimum amount communicated by the Employer and a maximum amount of $3,400 per Plan Year, as adjusted for inflation in subsequent Plan Years. You will be required to pay the annual Health FSA contribution equal to the coverage level that you have chosen.

When you complete the Election Form/Salary Reduction Agreement, you specify the amount of Health FSA Benefits that you wish to pay for with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

> *Example:* Assume that for the Plan Year, you have elected to be reimbursed up to $1,000 for Medical Care Expenses and that you have chosen no other benefits under the Cafeteria Plan. If you pay all of your contributions, then your Health FSA Account would be credited with a total of $1,000 during the Plan Year. If you are paid biweekly, then your Health FSA Account would reflect that you have paid $38.46 ($1,000 divided by 26) each pay period in contributions for the Health FSA Benefits that you have elected.

Q-20. What are Health FSA carryovers?

You may carry over up to $680 (as adjusted for inflation in subsequent Plan Years) of unused amounts remaining in your Health FSA at the end of a Plan Year to be used for Medical Care Expenses incurred during the next Plan Year. This applies only to the Health FSA—carryovers are not permitted under the DCAP. No more than $680 of your unused Health FSA amount for a Plan Year (as adjusted for inflation in subsequent Plan Years) may be carried over for use in the next Plan Year.

> *Example:* At the end of a 2026 calendar plan year, your unused health FSA amount is $800. You may carry over up to $680 to reimburse 2027 plan year expenses. However, the entire $800 is also available to reimburse 2026 plan year expenses during the 2026 run-out period (see Q-24). Assume that, during the run-out period for 2026, you submit and are reimbursed for 2026 expenses of $350. This leaves you with a carryover of $450 ($800 − $350), which can be used for 2027 expenses. On the other hand, if you do not submit 2026 expenses during the run-out period, you will be able to carry over the maximum permitted amount of

$680. The remaining amount will be forfeited (see Q-25 and Q-26).

Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit, and they will not count toward the maximum dollar limit on annual salary reductions under the Health FSA (see Q-19).

Example: Assume that for 2027, you elect the maximum Health FSA Benefit amount permitted under the Plan. Your election will not affect your carryover, and you can also carry over the maximum permitted amount of $680 from 2026 to 2027.

If you are otherwise eligible for the Health FSA for a Plan Year but you do not make a Health FSA election for that Plan Year, you may still use any carryovers from the preceding Plan Year for current or preceding Plan Year Medical Care Expenses (in accordance with Plan terms). However, you must be a participant in the Health FSA as of the last day of the Plan Year to benefit from the carryover. Termination of employment and cessation of eligibility will generally result in a loss of carryover eligibility unless a COBRA election is made (see Q-12).

Under IRS rules, if you carry over any unused Health FSA amounts to a General-Purpose Health FSA, you (and any other individual whose expenses can be reimbursed by your Health FSA) cannot contribute to an HSA during the entire next Plan Year. If you (or someone else whose expenses can be reimbursed by your Health FSA) would like to contribute to an HSA during the next Plan Year, you must waive (decline) the carryover before that Plan Year begins. If you waive the carryover, you may continue to submit claims for expenses incurred during the preceding Plan Year until the end of the Run-Out Period, to be reimbursed from your available Health FSA amounts. If those claims do not use up your entire Health FSA balance for the preceding Plan Year, any unused amounts will be forfeited in accordance with your waiver.

Note that the Health FSA cannot offer both the carryover and the grace period. See the "Plan Components Offered" section at the beginning of this Summary for the specific features offered by your Health FSA.

Q-21. What amounts will be available for Health FSA reimbursement at any particular time during the Plan Year?

The full amount of Health FSA coverage that you have elected (reduced by prior reimbursements made during the same Plan Year) will be available to reimburse you for qualifying Medical Care Expenses incurred during the Plan Year, regardless of the amount that you have contributed when you submitted the claim (so long as you have continued to pay the contributions). In future years, the amount of Health FSA coverage that is available to you will be increased by the amount of your carryovers, if any (see Q-20).

Example: Suppose that for a calendar plan year, you elected $1,000 of coverage and

contributed to your Health FSA Account (as described in Q-20) during January and February-that means that by February 23 you would have contributed $153.84 ($38.46 multiplied by 4 pay periods). On February 26 you incur a Medical Care Expense in the amount of $300. You submit that claim for reimbursement on February 27. So long as the claim meets all applicable requirements, the $300 would be available to you for that expense, even though you have only contributed $153.84 to your Health FSA Account at that point.

You may also be able to be reimbursed from unused amounts remaining in your Health FSA Account at the end of a Plan Year for Medical Care Expenses incurred during a "grace period" following the end of the Plan Year. (See Q-23.)

Note that only reasonable quantities of over-the-counter (OTC) drugs will be reimbursed from your Health FSA Account in a single calendar month, even if the drugs otherwise meet the requirements for reimbursement, including that they are for medical care under Code §213(d). (See Q-22.) Stockpiling is not permitted.

Q-22. What are Medical Care Expenses that may be reimbursed from the Health FSA?

Your Health FSA election may be for only one of the following:

- General-Purpose Health FSA Coverage

Each of these Health FSA coverage options is described in detail below. Note:

The eligible Medical Care Expenses vary according to the type of Health FSA coverage option that is elected, as described below.

(a) *General-Purpose Health FSA Coverage Option.* For purposes of the General-Purpose Health FSA Coverage Option, "Medical Care Expense" means expenses incurred by you, your Spouse, or your Dependents for "medical care" as defined in Code §213(d) (including expenses for menstrual care products). However, as described above, only reasonable quantities of OTC drugs will be reimbursed from your Health FSA Account in a single calendar month. The following list shows certain expenses that are not reimbursable, even if they meet the definition of medical care under Code §213(d) and may otherwise be reimbursable under IRS rules governing Health FSAs.
EXCLUSIONS:

- health insurance premiums for any other plan (including premiums for a plan sponsored by the Employer, such as the Health Plan);
- long-term care services;

- cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease ("cosmetic surgery" means any procedure that is directed at improving the patient's appearance and that does not meaningfully promote the proper function of the body or prevent or treat illness or disease);
- the salary expenses of a nurse to care for a healthy newborn at home;
- funeral and burial expenses;
- household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework);
- custodial care;
- costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods;
- social activities, such as dance lessons (even if recommended by a physician for general health improvement);
- bottled water;
- cosmetics, toiletries, toothpaste, etc.;
- uniforms or special clothing, such as maternity clothing;
- automobile insurance premiums;
- transportation expenses of any sort, including transportation expenses to receive medical care;
- marijuana and other controlled substances that are in violation of federal law, even if prescribed by a physician;
- any item that doesn't constitute "medical care" under Code §213(d); and
- any item that isn't reimbursable under applicable regulations.

For more information about what items are-and are not-Medical Care Expenses, consult IRS Publication 502 (Medical and Dental Expenses) under the headings "What Medical Expenses Are Includible?" and "What Expenses Are Not Includible?" But use IRS Publication 502 with caution, because it was meant only to help taxpayers figure out what medical expenses can be deducted on the Form 1040 Schedule A (i.e., to figure out their tax deductions), not what is reimbursable under a Health FSA. In fact, some statements in IRS Publication 502 aren't correct when determining whether that same expense is reimbursable from your Health FSA, because there are differences between what is deductible as medical care (under Code §§213(a) and 213(b)) and what is reimbursable as medical care under a Health FSA (under Code §213(d)). Not all expenses that are deductible are reimbursable under a Health FSA, and not all expenses that

are reimbursable under a Health FSA are deductible. *Examples:* Health insurance premiums, founders' fees, lifetime care, long-term contracts, and long-term care services are listed as deductible expenses in Publication 502, but generally they cannot be reimbursed from your Health FSA. And Health FSAs may reimburse OTC drugs if they qualify as medical care under Code §213(d), but they are still not deductible under Code §§213(a) and 213(b).

Ask the Third-Party Administrator if you need further information about which expenses are-and are not-likely to be reimbursable, but remember that the Third-Party Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Q-23. When must the Medical Care Expenses be incurred for the Health FSA?

For Medical Care Expenses to be reimbursed to you from your Health FSA Account for a Plan Year, they must have been incurred during that Plan Year. In addition, as discussed below, you may be able to be reimbursed from unused amounts remaining in your Health FSA Account at the end of a Plan Year for Medical Care Expenses incurred during a "grace period" following the end of the Plan Year. Grace periods will begin on the first day following the end of the Plan Year and will end 2 months and 15 days later.

A Medical Care Expense is incurred when the service that causes the expense is provided, not when the expense was paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. You may not be reimbursed for any expenses incurred before the Health FSA or the Cafeteria Plan became effective, before your Election Form/Salary Reduction Agreement became effective, or after a separation from service (except for continuation coverage, as described in Q-12 and Attachment 2, found at the end of this Summary). Expenses incurred during a subsequent Plan Year can only be reimbursed from your Health FSA Account for that Plan Year.

Example: If you prepay on the first day of the month for medical care that will be given during the rest of the month, the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month).

In order to take advantage of the grace period, you must be a Participant in the Plan with Health FSA coverage that is in effect on the last day of the Plan Year to which the grace period relates. See Q-24 regarding certain rules that apply to claims for reimbursement for Medical Care Expenses that are incurred during a grace period.

Note that the Health FSA cannot offer both the carryover and the grace period. See the “Plan Components Offered” section at the beginning of this Summary for the specific features offered by your Health FSA.

Q-24. What must I do to be reimbursed for Medical Care Expenses from the Health FSA?

When you incur an expense that is eligible for payment, you must submit a claim to the Third-Party Administrator. You must include written statements and/or bills from independent third parties stating that the Medical Care Expenses have been incurred and stating the amount of such Medical Care Expenses, along with the Health FSA Reimbursement Request Form. Generally, this requires including an Explanation of Benefits (EOB) Form from the medical insurance carrier (or a bill from a doctor's office) indicating the amounts that you are obligated to pay. Further details about what must be provided are contained in the Health FSA Reimbursement Request Form.

If you have paid the contributions for the Health FSA coverage that you have elected, then you will be reimbursed for your eligible Medical Care Expenses within 30 days after the date you submitted the Health FSA Reimbursement Request Form (subject to a 15-day extension for matters beyond the Plan Administrator's control-see Q-11). Claims will be paid in the order in which they are approved. Remember, though, that you can't be reimbursed for any total expenses above the annual reimbursement amount that you have elected.

You will have until the end of the Run-Out Period in which to submit a claim for reimbursement for Medical Care Expenses incurred during the previous Plan Year. However, if you have ceased to be eligible as a Participant, you will only have until 90 days after the date you ceased to be eligible in which to submit claims for reimbursement for Medical Care Expenses incurred prior to the date on which you ceased to be eligible. You will be notified in writing if any claim for benefits is denied. (See Q-11.)

The following additional rules will apply to a Health FSA that offers the carryover feature:

- Medical Care Expenses incurred during a Plan Year will be reimbursed first from your unused amounts credited for that Plan Year and then from amounts carried over from the preceding Plan Year. Carryovers that are used to reimburse a current Plan Year expense will reduce the amount available to pay your preceding Plan Year expenses. Once paid, a claim will not be reprocessed or otherwise recharacterized so as to change the Plan Year from which funds are taken to pay it.
- *Example:* At the end of a 2026 calendar plan year, your unused health FSA amount is $800. You elect Health FSA salary reductions of $2,400 for 2027. In January 2027, you submit 2026 Medical Care Expenses of $2,700. The entire $2,700 will be reimbursed with the $2,400 you elected for 2027 and $300 of the $800 remaining from 2026. You will then have $500 remaining to reimburse any 2026 Medical Care Expenses submitted during the run-out period, and you may carry over up to $380 ($680 maximum less the $300 already reimbursed). Thus, if you submit 2026 run-out period expenses of $750 in February 2026, only $500 of these expenses can be reimbursed, and you will have no amounts remaining to reimburse 2027 expenses.

The following additional rules will apply to a Health FSA that offers the grace period feature:

- Medical Care Expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. *Example:* Assume that $100 remains in your Health FSA Account at the end of a 2026 calendar plan year and that you have also elected $2,400 of Health FSA coverage for 2027. If you submit a $200 Medical Care Expense that was incurred in January 2027, $100 of your claim will be paid out of the unused amounts remaining in your Health FSA Account from the 2026 plan year. The remaining $100 will be paid out of the amounts that are available to reimburse you for Medical Care Expenses incurred in the 2027 plan year.
- Once paid, a claim will not be reprocessed or otherwise recharacterized so as to change the Plan Year from which funds are taken to pay it. For this reason, if you also have Health FSA coverage for the new year, you may want to wait to submit Medical Care Expenses you incur during the grace period until you are sure you have no remaining unreimbursed expenses from the prior Plan Year.
- *Example:* Using the same facts as in the previous example, assume that a few days after being reimbursed for the $200 grace period expense, you discover $100 of 2026 Medical Care Expenses that have not been submitted for reimbursement. You cannot be reimbursed for the newly discovered expenses because no amounts remain to reimburse you for 2026 expenses. The Plan will not reprocess the $200 grace period expense so as to pay it entirely from your 2027 Health FSA amounts.
- Expenses incurred during a grace period must be submitted by the end of the Run-Out Period to which the grace period relates in order to be reimbursed from amounts remaining at the end of that Plan Year. (As discussed above, the end of the Run-Out Period is also the deadline for submitting any claims for reimbursement of Medical Care Expenses incurred during the preceding Plan Year.)

Note that the Health FSA cannot offer both the carryover and the grace period. See the "Plan Components Offered" section at the beginning of this Summary for the specific features offered by your Health FSA.

If the Employer implements an electronic payment card program (debit card, credit card, or similar method) to pay expenses from the Health FSA, some expenses may be validated at the time the expense is incurred (like copays for medical care). For other expenses, the card payment is only conditional and you will still have to submit supporting documents. You will receive more information from the Employer or Third-Party Administrator about what you must do to obtain reimbursement if such a system is

implemented.

Q-25. Is there any risk of losing or forfeiting the amounts that I elect for Health FSA Benefits?

Yes. If the Medical Care Expenses that you incur during the Plan Year or during the grace period immediately following the Plan Year (if you are eligible for the grace period-see Q-23) are less than the annual amount that you elected for Health FSA Benefits (increased by any carryovers from the previous Plan Year, if applicable), you will forfeit any amounts that are not eligible for carryover to the following Plan Year as provided in Q-20. This is called the use-or-lose rule under applicable tax laws. The difference between what you elected (increased by any carryovers from the previous Plan Year, if applicable) and the Medical Care Expenses that were reimbursed will be forfeited at the end of the time limits described in Q-26 to the extent not carried over as provided in Q-20.

Q-26. What are the time limits that affect forfeiture of my Health FSA Benefits (and what happens to amounts that are forfeited)?

You will forfeit any amounts in your Health FSA Account that are not applied to pay expenses submitted by the end of the Run-Out Period for which the election was effective or carried over as provided in Q-20 (except that if you have ceased to be eligible as a Participant, you may forfeit such amounts at an earlier date-see Q-24). Forfeited amounts may be used as follows: to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; to reduce the cost of administering the Health FSA during the Plan Year and the subsequent Plan Year; and/or to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable law or IRS guidance. Also, any Health FSA Account benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

Q-27. Will I be taxed on the Health FSA Benefits that I receive?

Generally, you will not be taxed on your Health FSA Benefits, up to the limits set forth in Q-19. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit.

> *Example:* To qualify for tax-free treatment, your Medical Care Expenses must meet the definition of "medical care" as defined in the Code. If you are reimbursed for a claim that is later determined to not be for Medical Care Expenses, then you will be required to repay the amount. Alternatively, the Plan Administrator may offset the amount against any other

Medical Care Expenses submitted for reimbursement or withhold the amount from your pay.

HSA Component

Q-28. Are HSA Benefits a component of the Plan?

No, HSA Benefits are not a component of the Plan.

ERISA Rights

Q-50. What are my ERISA Rights?

The Cafeteria Plan and DCAP Components are not ERISA welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA). However, the Health FSA Component and the Health Plan are governed by ERISA.

Note: This Summary Plan Description does not describe the Health Plan. Consult the Health Plan documents and the separate Summary Plan Descriptions for the Health Plan.

The Health FSA and DCAP Components are self-funded by the Employer and are contract administration plans. The Third-Party Administrator processes claims for these Components, but the Employer pays the claims out of its general assets. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of these Components. There is no trust for the Plan or any component.

The Health FSA Component is a group health plan subject to ERISA. The named fiduciary for the Health FSA Component is the Employer, its plan records are kept on the Plan Year basis, and its plan number is 501.

Your Rights

As a participant in the Cafeteria Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Employer, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA Rights

Continue your Health Plan coverage (and, in some cases, your Health FSA coverage) for yourself, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Employer, as Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (see Q-11), you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for

asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact 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.

HIPAA Privacy Rights

Under HIPAA, group health plans (including the Health FSA) are required to take steps to ensure that certain "protected health information" (PHI) is kept confidential. You may receive a separate notice from the Employer (or medical insurers) that outlines its health privacy policies, including with regard to electronic PHI.

Additional General Information

Q-51. What other general information should I know?

This Q-51 contains certain general information that you may need to know about the Plan.

Qualified Medical Child Support Order

The Health FSA will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA §609(a). The Health FSA has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Amendment and Termination

Although the Employer intends to continue the Plan indefinitely, the Employer reserves the right to amend or terminate the Plan at any time and for any reason. If either of these actions is taken, you will be notified.

No Contract of Employment

The Plan does not constitute a contract of employment between you and the Employer, nor does your participation in the Plan give you any rights to continue as an employee of the Employer. All employees remain subject to termination, layoff, or discipline as if the Plan had not been put into effect.

Attachment 1

When Can I Change Elections Under the Cafeteria Plan During the Plan Year?

Participants can change their elections under the Cafeteria Plan during a Plan Year if an event occurs that is a Change in Election Event and certain other conditions are met, as described below. For details, see the various Change in Election Events headings below for the specific type of Change in Election Event: Leaves of absence, including FMLA leave (defined in Q-14); Changes in Status; Special Enrollment Rights; Certain Judgments, Decrees, and Orders; Medicare or Medicaid; Changes in Cost; Changes in Coverage; and Changes in HSA Elections. Note that the Change in Election Events do not apply for all Benefits-applicable exclusions are described under the relevant headings. In addition, the Plan Administrator can change certain elections on its own initiative-see Q-7. Note also that no changes can be made with respect to Health Plan Benefits if they are not permitted under the Health Plan.

If any Change in Election Event occurs, you must inform the Plan Administrator and complete a new Election Form/Salary Reduction Agreement within 30 days after the occurrence (or within 60 days after the occurrence in the case of a special enrollment right due to loss of eligibility for Medicaid or state children's health insurance program coverage, or eligibility for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the Health Plan). If the change involves a loss of your Spouse's or Dependent's eligibility for Health Plan Benefits, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

The Plan is designed to allow all plan changes permitted by the IRS Change in Election Event rules, including both Change in Election Events allowed under current laws and regulations and any subsequently approved Change in Election Events.

1. Leaves of Absence *(Applies to Health Plan Benefits, Health FSA, and DCAP Benefits).* You may change an election under the Cafeteria Plan upon FMLA and non-FMLA leave only as described in Q-14.

2. Change in Status *(Applies to Health Plan Benefits, Health FSA Benefits (as limited below), and DCAP Benefits).* If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described in item 3 below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

- a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal

separation, or annulment);

- a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
- any of the following events that change the employment status of you, your Spouse, or your Dependent and that affect benefits eligibility under a cafeteria plan (including this Cafeteria Plan) or other employee benefit plan of you, your Spouse, or your Dependents: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;
- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age, ceasing to be a student, or a similar circumstance); or
- a change in your, your Spouse's, or your Dependent's place of residence.

3. Change in Status-Other Requirements *(Applies to Health Plan Benefits, Health FSA Benefits (as limited below), and DCAP Benefits).* If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility .

Election changes may not be made to reduce Health FSA coverage during a Plan Year; however, election changes may be made to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of your Spouse, divorce, legal separation, or annulment; death of your Dependent; change in employment status such that you become ineligible for Health FSA coverage; or your Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage (e.g., on account of attaining a specific age). But if you cancel coverage, it cannot result in your contributions for the year being less than the amount for which you have already been reimbursed.

> *Example:* Assume that you elected to contribute $100 per month to the Health FSA and in February you were reimbursed for expenses in the amount of $700. If a Change in Status Event occurs in March that allows you to cancel coverage, your cancellation will not take

effect until you have contributed a total of $700 for the year. (See also Q-20 and Q-21.)

In addition, you must satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Spouse or Dependent Eligibility; Special COBRA Rules*. For accident and health benefits (here, the Health Plan and Health FSA Benefits), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status. However, if you, your Spouse, or your Dependent elects COBRA continuation coverage under the Employer's plan because you ceased to be eligible because of a reduction of hours or because your Dependent ceases to satisfy eligibility requirements for coverage, and if you remain a Participant under the terms of this Cafeteria Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage. See the Plan Administrator for more information. *Example:* Employee Mike is married to Sharon, and they have one child. The employer offers a calendar-year cafeteria plan that allows employees to elect any of the following: no medical coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to revoke his previous election and elect no medical coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel medical coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

- *Gain of Coverage Eligibility Under Another Employer's Plan*. For a Change in Status in which you,

your Spouse, or your Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Cafeteria Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

4. Special Enrollment Rights *(Applies Only to Major Medical Component of Health Plan Benefits).* In certain circumstances, enrollment for Health Plan Benefits may occur outside the Open Enrollment Period, as explained in materials provided to you separately describing the Health Plan Benefits. (The Employer's Special Enrollment Notice also contains important information about the special enrollment rights that you may have.) When a special enrollment right explained in those separate documents applies to your Health Plan Benefits, you may change your election under the Cafeteria Plan to correspond with the special enrollment right.

5. Certain Judgments, Decrees, and Orders *(Applies to Health Plan Benefits and Health FSA Benefits, but Not to DCAP Benefits).* If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your child (including a foster child who is your Dependent) to be covered under the Health Plan Benefits or Health FSA Benefits, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child, provided that such coverage is, in fact, provided for the child.

6. Medicare or Medicaid *(Applies to Health Plan Benefits, and Health FSA Benefits (as limited below), but Not to DCAP Benefits).* If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Health Plan and/or your Health FSA coverage may be canceled completely but not reduced. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's accident or health coverage (here, Health Plan and/or Health FSA Benefits, as applicable).

7. Change in Cost *(Applies to Health Plan Benefits, and DCAP Benefits (as limited below), but Not to Health FSA Benefits).* If the cost charged to you for your Health Plan Benefits or DCAP Benefits significantly increases during the Plan Year, then you may choose to do any of the following:

- make a corresponding increase in your contributions;
- revoke your election and receive coverage under another benefit package option (if any) that

provides similar coverage, or elect similar coverage under the plan of your Spouse's employer;

- drop your coverage, but only if no other benefit package option provides similar coverage.

For these purposes, the Health FSA is not similar coverage with respect to the Health Plan Benefits; an HMO and a PPO are considered to be similar coverage (the Employer currently offers an HMO and a PPO); and coverage under another employer plan, such as the plan of a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage. If the cost of Health Plan or DCAP Benefits significantly decreases during the Plan Year, then the Plan Administrator may permit the following election changes:

- if you are enrolled in the benefit package option that has decreased in cost, you may make a corresponding decrease in your contributions;
- if you are enrolled in another benefit package option (such as the HMO option under the Health Plan), you may change your election on a prospective basis to elect the benefit package option that has decreased in cost (such as the PPO option under the Health Plan); or
- if you are otherwise eligible, you may elect the benefit package option that has decreased in cost on a prospective basis, subject to the terms and limitations of the benefit package option.

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost.

The Plan Administrator generally will notify you of increases or decreases in the cost of Health Plan benefits.

8. Change in Coverage *(Applies to Health Plan Benefits and DCAP Benefits, but Not to Health FSA Benefits).* You may also change your election if one of the following events occurs:

- *Significant Curtailment of Coverage.* If your Health Plan Benefits or DCAP Benefits coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Health Plan Benefits), then you may revoke your election for that coverage and elect coverage under another benefit package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally-loss of one particular physician in a network does not constitute significant curtailment.) If your Health Plan Benefits or DCAP Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefit package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage, but only if there is no option available under the

plan that provides similar coverage. (The Plan Administrator generally will notify you of significant curtailments in Health Plan Benefits coverage; you generally will have to notify the Plan Administrator of significant curtailments in DCAP Benefits coverage.)

- *Addition or Significant Improvement of Cafeteria Plan Option.* If the Cafeteria Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.
- *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).
- *Change in Election Under Another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Cafeteria Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.

9. Reduction of Hours *(Applies to Only to Major Medical Component of Health Plan Benefits).* If you were reasonably expected to average 30 hours of service or more per week and experience an employment status change such that you are no longer reasonably expected to average 30 hours of service or more per week, you may prospectively revoke your election for Health Plan coverage, provided that you certify that you and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing minimum essential coverage under health care reform that is effective no later than the first day of the second month following the month that includes the date the Health Plan coverage is revoked.

10. Exchange Enrollment *(Applies to Only to Health Plan Benefits).* If you are eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during a special or annual open enrollment period, you may prospectively revoke your election for Health Plan coverage, provided that you certify that you and any related 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 Health Plan coverage.

Attachment 2

COBRA Continuation Coverage Rights Under the Health FSA Component

Introduction

The following paragraphs generally explain COBRA coverage under the Health FSA Component, when it may become available to you and your family, and what you need to do to protect the right to receive it. The description of COBRA coverage contained in this Attachment applies only to the Health FSA Component of the Plan and not to any other benefits offered under the Plan or by the Employer. See the booklets for the Health Plan for information about COBRA continuation coverage under those plans.

What Is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section entitled "Who Is Entitled to Elect COBRA?"

COBRA Coverage May Become Available to "Qualified Beneficiaries." After a qualifying event occurs and any required notice of that event is properly provided to the Employer, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA Coverage Under the Health FSA Component

COBRA Coverage Is Offered Only in Limited Circumstances. COBRA coverage under the Health FSA Component will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year.

Health FSA COBRA Coverage Lasts Only Until the End of the Plan Year; Carryover Rights. Participants with underspent accounts can receive Health FSA COBRA coverage only through the end of the plan year in which the COBRA qualifying event occurs. However, qualified beneficiaries who continue COBRA coverage through the end of the Plan Year may carry over up to $660 of unused Health FSA amounts remaining at the end of that plan year in accordance with the Plan's provisions regarding Health FSA

carryovers, until the end of the 18-, 29-, or 36-month maximum COBRA coverage period that applies under the Health Plan or until the amounts are used up, if earlier.

All Qualified Beneficiaries Are Covered Together Under the Health FSA Unless Otherwise Elected. Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact the Employer for more information.

No Health FSA Open Enrollment. Qualified beneficiaries may not enroll in the Health FSA at open enrollment.

Who Is Entitled to Elect COBRA?

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a qualified beneficiary.

Qualifying Events for the Covered Employee. If you are an employee, you will be entitled to elect COBRA if you lose coverage under the Health FSA Component because either one of the following qualifying events happens:

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

Qualifying Events for the Covered Spouse. If you are the spouse of an employee, you will be entitled to elect COBRA if you lose coverage under the Health FSA Component because any of the following qualifying events happens:

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct; or
- you become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your coverage under the Health FSA Component in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

If you are the Dependent child of an employee, you will be entitled to elect COBRA if you lose coverage under the Health FSA Component because any of the following qualifying events happens:

- your parent-employee dies;
- your parent-employee's hours of employment are reduced;
- your parent-employee's employment ends for any reason other than his or her gross misconduct; or
- you stop being eligible for coverage under the Plan as a Dependent (see Q-2).

Electing COBRA After Leave Under the Family and Medical Leave Act (FMLA). Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the Health FSA Component during the leave. Contact the Employer for more information about these special rules.

When Is COBRA Coverage Available?

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage under the Health FSA Component to qualified beneficiaries. You need not notify the Employer of any of these qualifying events.

*You Must Notify the Plan Administrator of Certain Qualifying Events by This Deadline.*For the other qualifying events (divorce or legal separation of the employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), a COBRA election will be available to you only if you notify the Employer in writing within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

*No COBRA Election Will Be Available Unless You Follow the Plan's Notice Procedures and Meet the Notice Deadline.*In providing this notice, you must use the Plan's form entitled "Notice of Qualifying Event Form" (you may obtain a copy of this form from the Employer at no charge), and you must follow the notice procedures specified in the section below entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to the Employer during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

Electing COBRA Coverage

*How to Elect COBRA.*To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and mail or hand-deliver it to the Employer. (An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Form from the Employer.) You may provide the Election Form only by mail or hand-delivery. Delivery by another method, including by fax or email, is not acceptable.

*Deadline for COBRA Election.*If mailed, your election must be postmarked (or if hand-delivered, your election must be received by the individual at the address specified on the Election Form) no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event (or, if later, 60 days after the date that Plan coverage is lost). IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

Independent Election Rights. Each qualified beneficiary will have an independent right to elect COBRA. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

Length of COBRA Coverage

COBRA coverage under the Health FSA Component is temporary and can last only until the end of the plan year in which the qualifying event occurred-see the section above entitled "COBRA Coverage Under the Health FSA Component."

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

COBRA coverage under the Health FSA Component will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time; or
- the employer ceases to provide any group health plan for its employees.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the Plan (including both employee and any employer contributions but disregarding any carryovers from the previous plan year) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

Payment for COBRA Coverage

How Premium Payments Must Be Made. Unless you are able to continue eligibility in the Cafeteria Plan and pay your COBRA premiums on a pre-tax basis as described in Attachment 1, all COBRA premiums must be paid by check. Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the individual at the payment address specified in the election notice provided to you

at the time of your qualifying event. However, if the Plan notifies you of a new address for payment, you must mail or hand-deliver all payments for COBRA coverage to the individual at the address specified in that notice of a new address.

When Premium Payments Are Considered to Be Made. If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

First Payment for COBRA Coverage. If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.) See the section above entitled "Electing COBRA Coverage."

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.) You are responsible for making sure that the amount of your first payment is correct. You may contact the Employer using the contact information provided below to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Monthly Payments for COBRA Coverage. After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. The Employer will not send periodic notices of payments due for these

coverage periods (that is, we will not send a bill to you for your COBRA coverage-it is your responsibility to pay your COBRA premiums on time).

Grace Periods for Monthly COBRA Premium Payments. Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month so long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for reimbursement of a medical expense incurred while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

More Information About Individuals Who May Be Qualified Beneficiaries

Children Born to or Placed for Adoption With the Covered Employee During a Period of COBRA Coverage. A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate Recipients Under QMCSOs. A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Employer during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Notice Procedures

If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA.

Notices Must Be Written and Submitted on Plan Forms

Any notice that you provide must be in writing and must be submitted on the Plan's required form (the Plan's required forms are described above in this SPD, and you may obtain copies from the Employer without charge). Oral notice, including notice by telephone, is not acceptable. Electronic (including emailed or faxed) notices are not acceptable.

How, When, and Where to Send Notices

You must mail your notice to the administrator listed on the form. Delivery by another method, including by fax or email, is not acceptable unless specifically permitted on the form.

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice period is described in the paragraph above entitled "You must notify the plan administrator of certain qualifying events by this deadline.")

Information Required for All Notices

Any notice you provide must include (1) the name of the Plan; (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary/beneficiaries who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event

If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the Employer that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the Employer that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Who May Provide Notices

The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

Strategic Funding Source Inc. dba Kapitus

Transportation Benefit Plan

Amended and Restated January 1, 2026

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INTRODUCTION

Strategic Funding Source Inc. dba Kapitus Transportation Benefit Plan ("Plan") has been established by Strategic Funding Source Inc. dba Kapitus (the "Company" or the "Employer") to allow Eligible Employees to pay for certain transportation and/or parking costs on a pre-tax basis. There are specific benefits that you may elect, and they are outlined in this Summary Plan Description.

The benefits provided under this Plan are intended to be excludable from gross income under Section 132(f) of the Internal Revenue Code.

Read this Summary Plan Description (this "SPD") carefully so that you understand the provisions of the Plan and the benefits you can receive.

This SPD was designed to provide you with information regarding the Company's Transportation Benefit Plan. If this SPD does not answer all of your questions, please contact the Plan Administrator (or other assigned person). The name and address of the Plan Administrator can be found in the Section of this SPD titled: "Plan Administrator Information".

I. Eligibility

1. **How can I participate in the Plan?**

   Before you can become a participant in the Plan, there are certain conditions that you must satisfy. First, you must be an active employee working 30 hours or more per week and meet the other eligibility requirements.

2. **When can I enter the Plan?**

   You can enter the Plan on the first of the month following the date you met the eligibility requirements.

3. **What must I do to enroll in the Plan?**

   Assuming you are eligible, you become a participant by signing an individual salary reduction agreement, thus electing to participate in the Plan.

II. Contributions

1. **Can I change my election during a coverage period?**

   Once a salary reduction agreement is entered into, it cannot be changed during the month to which it relates. However, changes may be made to your election for future months, provided that the change is made before the month to which it relates.

2. **What is my "Transportation Expense Reimbursement Account"?**

   If you elect benefits under the Plan, your employer will establish and maintain a transportation expense reimbursement account ("Account") to keep a record of the reimbursements to which you are entitled.

3. **How is my Account funded?**

When you complete the salary reduction agreement, you specify the amount of Eligible Transportation Expense benefits you wish to pay for with your salary reductions. Thereafter, your Account will be credited with that portion of your salary that you have elected to pay through salary reduction.

III. Benefits

1. **What is an "Eligible Transportation Expense"?**

Eligible Transportation Expenses include:

a. **"Parking Expenses"** - that is, expenses incurred to park your car on or near the business premises of your employer, or expenses incurred to park your car at a location from which you commute to work by (a) mass transit facilities, (b) a Commuter Highway Vehicle, or (c) carpool.

b. **"Transit Pass Expenses"** - that is, expenses incurred for a pass, token, fare card, voucher, or similar item (a "Pass") for transportation (a) on mass transit facilities, whether or not publicly owned, or (b) provided by any person in the business of transporting persons for compensation or hire if such transportation is provided in a vehicle with a seating capacity of at least six adults (excluding the driver). Transit Pass Expenses also include, but are not limited to, expenses incurred for any smartcard, terminal-restricted debit card or other debit card where the use of the card has been electronically restricted to the purchase of fare media for the appropriate transit system.

Any amount in the Participant's account that has not been used for reimbursement of Eligible Transportation or Parking Expenses incurred prior to the end of the Coverage Period and 90 day Run-out Period, will be carried over to the next plan year.

c. **"Commuter Highway Vehicle Expenses"** - that is expenses incurred for transportation in a "Commuter Highway Vehicle" if such transportation is in connection with travel between your residence and place of employment. A "Commuter Highway Vehicle" is any highway vehicle with a seating capacity of at least six adults (not including the driver), and for which at least 80% of the mileage (i) is for purposes of transporting employees in connection with travel between their residences and their places of employment, and (ii) is on trips during which the number of employees transported for such purposes is, on average, at least half of the adult seating capacity of the vehicle (not including the driver).

2. **What is the Maximum Qualified Transportation Expense benefit I may elect?**

The maximum amount you may contribute to the Account cannot exceed the maximum amount specified below:

For Parking Expenses: $340.00/month
For Transit Passes and Commuter Highway Vehicle Expenses (combined total): $340.00/month

These amounts are the maximum amounts that are excludable for federal income tax purposes. Some states may have lower amounts for state income tax purposes. Be sure to check with your employer or your state Department of Revenue to determine the excludable amount for state income tax purposes in your state.

IV. Benefit Payments

1. **How do I pay for expenses under the Plan?**

   When you incur an expense that is eligible for reimbursement, you must complete and submit a Request for Reimbursement (a "Request") to the Employer within 180 days after the date you incurred the expense; provided, all Requests must be submitted no later than 90 days after the end of the Plan Year in which the Eligible Transportation Expense is incurred. The Plan Administrator will provide you with acceptable forms for submitting these requests for reimbursement. As a general rule, you must submit a receipt (or other third party verification) along with your Request. You will be notified in writing if any request for reimbursement is denied. Cash reimbursement for mass transit is allowed only if Transit Passes, vouchers, debit cards or smart cards, (or some similar item that may be exchanged only for Transit Passes), are not readily available for direct distribution through your Employer.

   Your employer will provide you with a debit card or smartcard to use to pay for Eligible Transportation Expenses under the Plan. The Administrator will provide you with further details about the card.

2. **What happens to the money in my account when the plan year ends?**

   Any amount in the Participant's account that has not been used for reimbursement of Eligible Transportation or Parking Expenses incurred prior to the end of the Coverage Period and 90 day Run-out Period, will be carried over to the next plan year.

3. **What happens if my employment is terminated?**

   If your employment is terminated, all Requests must be submitted within 90 days after your termination date. Any funds in your Account for which a Request is not submitted within 90 days after your termination date will be forfeited.

4. **How long will the Plan remain in effect?**

   Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the Plan at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

5. **What happens if a request for reimbursement is denied?**

   If you are denied reimbursement under this Plan, the Employer or plan administrator will notify you in writing within 90 days of the date you submitted your Request. Such notification will set out the reasons your Request was denied.

6. **What effect will Plan participation have on Social Security and other benefits?**

   Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

   If you have any further questions regarding the terms of this Plan, please contact the Plan Administrator listed under the Section titled: "Plan Administrator Information" of this SPD.

V. General Information About The Plan

This Section contains certain general information which you may need to know about the Plan.

1. **General Plan Information**

   Strategic Funding Source Inc. dba Kapitus Transportation Benefit Plan is the name of the Plan. Your Employer has assigned Plan Number 620 to the Plan.

   The Plan's records are maintained on the basis of a twelve-month period. This is known as the Plan Year. The Plan Year begins on January 01 and ends December 31.

2. **Employer Information:**

   The Employer's name, address are:
   Strategic Funding Source Inc. dba Kapitus
   120 West 45th Street
   4th Floor New York, NY 10036

   Federal Employer I.D. Number: 01-0855279

3. **Plan Administrator Information:**

   Strategic Funding Source Inc. dba Kapitus
   120 West 45th Street
   4th Floor New York, NY 10036

4. **Type of Administration:**
   The type of Administration is Employer Administration

5. **Claims Questions:**
   Claims on expenses should be submitted to:
   Forma
   www.joinforma.com

   The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions you may have about the Plan. You may contact the Plan Administrator for any further information about the Plan.