THE HERITAGE GROUP CAFETERIA PLAN

(Effective January 1, 2025)

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ARTICLE I

INTRODUCTION

1.1 **Plan Purpose.** The Heritage Group Cafeteria Plan (the "Plan") is maintained by the Plan Sponsor to furnish Eligible Employees an opportunity to receive certain non-taxable benefits in lieu of taxable compensation. The cafeteria plan does not provide coverage; all coverage issues are subject to the terms and conditions of the applicable plan documents.

1.2 **Cafeteria Plan.** The Plan is intended to be a cafeteria plan under Code § 125, so that an election made by a Participant to forego compensation does not result in taxable income to the Participant. Appendix A of the Plan consists of a health care flexible spending account intended to qualify as a medical reimbursement under Code § 105; Appendix B of the Plan consists of a dependent care expense reimbursement arrangement that is intended to be a dependent care assistance program under Code § 129; Appendix C of the Plan consists of a health savings account that is intended to be available upon enrollment in a high deductible health plan under Code 223

1.3 **Effective Date.** The Plan is effective January 1, 2025.

1.4 **Applicability of the Plan.** The Plan shall apply only to eligible individuals who are Employees of a Participating Employer on or after the Effective Date, except to the extent the Plan expressly covers an individual as a former Employee or as a Dependent of a former Employee, such as in the case of any continuation coverage described in Section 4.6. The rights and benefits of Eligible Employees whose employment terminated prior to the Effective Date shall be determined in accordance with the Plan as in effect on the last day such Employees were employed by a Participating Employer; provided that Employees who elect continuation coverage following a Termination of Employment may have benefit terms modified or amended to the same extent that similarly situated active Employees may have benefit terms modified or amended under the Plan.

ARTICLE II

DEFINITIONS AND CONSTRUCTION

2.1 **Definitions.**

(a) "Account" means a bookkeeping account established for a Covered Employee by the Plan Sponsor, which may be either of the following:

(1) "Limited Purpose Health Care Flexible Spending Account" for reimbursement of Covered Health Care Expenses under Appendix A.

(2) "Dependent Care Flexible Spending Account" for reimbursement of dependent care expenses under Appendix B.

(3) "Health Savings Account" under Appendix C.

(b) "Affiliate" means any corporation that is a member of an The Heritage Group "controlled group" as defined in Code § 414(b), any business entity that is under common control with The Heritage Group or a related entity as defined in Code § 414(c), any business entity that is a member of an affiliated service group with The Heritage Group or a related entity as defined in Code § 414(m), or any other business entity that is required to be aggregated and treated as one employer with The Heritage Group or a related entity under Code § 414(o).

(c) "Board" means the Board of Directors of the Plan Sponsor.

(d) "Carryover Amount" means, with respect to a Covered Employee's Health Care Flexible Spending Account, an amount that is equal to the lesser of (a) any unused credit balance as of the end of the immediately preceding Plan Year in the Covered Employee's Health Care Flexible Spending Account (as of the date by which the Covered Employee must submit claims for reimbursement from the Health Care Flexible Spending Account for such Plan Year), or (b) $550 (or such greater amount as permitted by law and determined by the Benefits Committee from time to time).

(e) "Change in Family Status" means any of the following events:

(1) The Covered Employee marries.

(2) The Covered Employee divorces or is legally separated from his/her Spouse/Domestic Partner or has his/her marriage annulled.

(3) The Spouse/Domestic Partner or dependent of the Covered Employee dies.

(4) A child is born to or adopted by (or placed for adoption with) the Covered Employee.

(5) A dependent of the Covered Employee becomes or ceases to be eligible for coverage as a result of a change in age, disability status, or other similar circumstances.

(6) The Spouse/Dependent Partner or a dependent of the Covered Employee becomes employed or ceases to be employed.

(7) The Covered Employee, or the Spouse/Domestic Partner or a dependent of the Covered Employee, has a change in the terms and conditions of employment or has a reduction or increase in hours of employment, including a change from part-time to full-time status or vice versa, taking or returning from an unpaid leave of absence, or a strike or lock-out.

(8) The Covered Employee or the Covered Employee's Spouse/Domestic Partner or dependent has a change in place of residence or worksite.

(f) "Claims Administrator" means the individual, entity, or committee appointed by the Plan Administrator to review claims for benefits under the Plan and each Participating Program. The Claims Administrator for fully insured Participating Programs will be the insurance company issuing the applicable insurance policy or contract. The Claims Administrator for self-funded Participating Programs will be the Plan Administrator (or its delegate).

(g) "COBRA" means the provisions of Code § 4980B and ERISA §§ 601 through 608, as added to the Code and ERISA by the Consolidated Omnibus Budget Reconciliation Act of 1985.

(h) "Code" means the Internal Revenue Code of 1986, as amended.

(i) "Covered Dependent" means a Dependent of a Covered Employee whose coverage has become effective and has not terminated in accordance with Article III.

(j) "Covered Employee" means an Eligible Employee who satisfies the eligibility, participation, and coverage requirements of Article III, who has elected to participate in the Plan, and whose coverage has become effective and has not terminated in accordance with the provisions of Article III.

(k) "Dependent" means the Covered Employee's Spouse/Domestic Partner, and/or child (as defined under the applicable Program Document) who meets the eligibility requirements for a dependent set forth in the Program Document for a particular Participating Program or, if applicable, an individual who is determined to be an alternate recipient of a Covered Employee under a QMCSO.

(l) "Debit Card" means a stored-value card holding the value of the Covered Employee's Health Care Flexible Spending Account.

(m) "Election Period" means each of the following periods:

(1) "Initial Election Period" means the period established by the Plan Sponsor during which an Employee is eligible to make a Plan Election hereunder upon entering or reentering service as an Eligible Employee.

(2) "Annual Election Period" means the period preceding the first day of each Plan Year during which all Participants are eligible to make a Plan Election hereunder for the upcoming Plan Year.

(3) "Special Election Period" means the thirty-one (31) day period immediately following a Change in Family Status or other event described in Section 3.2(a)(2) that entitles the Participant to change his/her Plan Election for the remaining portion of the Plan Year; *except that*:

(A) If a child is born to or adopted by (or placed for adoption with) the Participant, "Special Election Period" with respect to such Participant means the thirty-one (31) day period immediately following the birth, adoption, or placement for adoption; or

(B) If a Participant who changes his/her Plan Elections under the Medical Plan consistent with any special enrollment rights under the Health Insurance Portability and Accountability Act relating to Medicaid or state Children's Health Insurance Program ("CHIP") coverage, "Special Election Period" with respect to such Participant is the sixty (60) day period immediately following the Medicaid or CHIP event.

The Plan Sponsor may in its sole discretion extend any Election Period for a Participant upon presentation by the Participant of evidence showing that the failure to file a Plan Election prior to the deadline was for good cause which was not the fault of the Participant.

(4) "Election Period for Health Savings Account Contributions" means, if permitted under Section 4.8(a), the one-month period preceding the month in which a Participant wishes to make a contribution to a Health Savings Account.

(n) "Eligible Employee" means the following:

(1) General Rule. "Eligible Employee" means any benefits eligible Employee or former Employee who is eligible to participate in and receive benefits under one or more Participating Programs and includes any Employee not participating in a Participating Program solely because he or she has not made a required Plan Election or has not completed a required waiting period.

(2) Collective Bargaining Employees. An Employee will not be an Eligible Employee during any period that he/she is covered by a bargaining agreement unless the agreement expressly provides for his/her participation in a Participating Program. For this purpose, a bargaining agreement will be deemed to continue after it expires during the pendency of collective bargaining negotiations until the parties have negotiated to "impasse" as determined by the applicable Participating Employer, and an Employee

thereafter will be an Eligible Employee if and only if participation is part of the impasse proposal of the Participating Employer or the Employee was an Eligible Employee before the collective bargaining agreement expired and the Participating Employer elects to continue such status. Eligibility of employees in a collective bargaining unit is subject to negotiations with the representative of that unit.

(3) Authorized Leaves of Absence Under FMLA and USERRA. An employee will continue as an Eligible Employee during any period that he/she is on a leave of absence under the Family and Medical Leave Act of 1993 ("FMLA") or USERRA provided he/she was an Eligible Employee immediately prior to such leave of absence, and further provided that he/she would have continued as an Eligible Employee if he/she had not been on the leave of absence.

(o) "Employee" means an individual who is treated as an active, full-time regular employee of a Participating Employer (i) who is paid a salary, wages, or other compensation by the Participating Employer; (ii) who is considered by the Participating Employer to be an employee at the time of the payment of such salary, wages, or other compensation; (iii) whose salary, wages, or other compensation is treated by the Participating Employer at the time of such payment as being subject to statutorily required payroll tax withholding, such as withholding of federal or state income or withholding of the employee's share of social security tax; and (iv) who is a seasonal employee working 1,200 hours between October-September (of the next calendar year).

Notwithstanding the foregoing, "Employee" shall not include the following categories of individuals, even if one or more of such individuals is determined by a court, the Internal Revenue Service ("IRS"), or any other entity under any federal or state law, rule, or regulation to be (or have been) a common law or statutory employee of a Participating Employer for some or all of the period of time in question:

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

(2) An individual who must be treated as an employee of a Participating Employer for limited purposes under the leased employee provisions of Code § 414(n).

(3) An individual covered by a collective bargaining agreement that does not provide for coverage under the Plan, if the type of benefits provided under the Plan were the subject of good faith bargaining between the individual's bargaining representative and a Participating Employer.

(4) An individual who is a non-resident alien and receives no United States source income.

(5) Special Rule in the Event of the Sale of a Business or Subsidiary. If an Eligible Employee ceases to be an Employee in connection with the sale of business assets of the Plan Sponsor or a Participating Employer to a third-party purchaser, or because his/her employer ceases to be an Affiliate (by reason of a sale or transfer of stock, or similar transaction), and such individual continues in the employ of the purchaser of such assets or continues in the employ of his/her employer (or a new affiliate thereof) after it ceases to be an Affiliate, such individual will be deemed to remain an Eligible Employee for any extended coverage period set forth in the asset or stock purchase agreement, or in any transition services agreement entered into in connection with such transaction, for purposes of the Health Care Flexible Spending Account and/or the Dependent Care Flexible Spending Account, as specified in such agreement.

(p) "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

(q) "High Deductible Health Plan" means a health plan benefit option offered under the Plan that is intended to qualify as a high deductible health plan under Code § 223(c)(2).

(r) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

(s) "Medical Plan" means any Participating Program that provides medical, dental, vision, or prescription drug coverage to Employees, whether provided through self-funding, group insurance, a health maintenance organization, or otherwise.

(t) "Health Savings Account" means a health savings account established under Code § 223.

(u) "Participant" means an individual described as such in Article III.

(v) "Participating Employer" means the Plan Sponsor or any Affiliate that has adopted the Plan for the benefit of its eligible employees, as listed in Appendix D.

(w) "Participating Program" means any of the employee benefit plans or programs offered to Employees through the Plan (including the medical expense reimbursement arrangement set forth in Appendix A, the dependent care expense reimbursement arrangement set forth in Appendix B and the health savings account arrangement set forth in Appendix C), as described in the Program Documents for such plan or program. The Plan Sponsor may add or delete the benefit programs provided under the Plan from time to time without the need for a formal amendment to the Plan.

(x) "Plan Election" means the written or electronic election made by an Employee to receive benefits under the Participating Programs for which the Employee is eligible as specified in the form or forms (for example, a benefit election form, a salary reduction agreement and/or a salary deduction agreement) required by that

Participating Program to be filed by the Employee with the Plan Administrator (or a representative of the Plan Administrator) in accordance with Article III.

(y) "Plan Year" means the 12-month period beginning January 1 and ending December 31.

(z) "Plan Sponsor" means The Heritage Group and any successor or assign thereof that adopts the Plan by action of its governing body or that contractually assumes the obligations of the Plan Sponsor under the Plan.

(aa) "Program Documents" means the written description of the terms of each separate Participating Program, including but not limited to a Summary Plan Description, schedule of benefits, benefits booklet, or insurance contract or certificate.

(bb) "QMCSO" means, in accordance with the requirements of ERISA § 609, a medical child support order that (i) creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive Health Benefits to which a Participant is eligible, (ii) satisfies the content requirements specified in ERISA § 609(a)(3), and (iii) does not require the Plan or any Participating Program to provide any type or form of benefit, or any option, not otherwise provided under the Plan or Participating Program, except to the extent necessary to meet the requirements of a law relating to medical child support described in Social Security Act § 1908.

(cc) "Salary Reduction Amount" means the amount designated by the Covered Employee in a Plan Election authorizing a Participating Employer to reduce the Covered Employee's compensation received during the Plan Year or portion of the Plan Year to which the Plan Election relates by the amount so designated and to contribute such amount, as a before-tax Participating Employer contribution or an after-tax employee contribution (as determined by the Plan Sponsor), on behalf of the Covered Employee toward the cost of the coverages specified by the Covered Employee in his or her Plan Election for each such type of contribution (to the extent permitted under the Plan).

(dd) "Spouse/Domestic Partner" means, with respect to each Participating Program, the definition of spouse/domestic partner set forth in the Program Documents for the particular Participating Program.

(ee) "Summary Plan Description" means the document that summarizes the terms of the Plan or a Participating Program that is subject to ERISA in a manner that is calculated to be understood by an average Participant, as required by ERISA § 102.

(ff) "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

(gg) "Termination of Employment" means resignation, discharge, failure to return to work at the end of an authorized leave of absence, retirement, death, or the happening of any other event or circumstance which results in the termination of

the employer-employee relationship between the individual and the Participating Employer and all Affiliates.

2.2 **Forum Selection and Choice of Law.** All lawsuits arising under or relating to a Participating Program that is self-insured by the Plan Sponsor must be submitted to the United States District Court for the Southern District of Indiana, Indianapolis Division. Lawsuits arising under or relating to a fully insured Participating Program must be submitted to the United States District Court for the Southern District of Indiana, Indianapolis Division if they name as a party the Plan Sponsor, a Plan Sponsor employee, a Plan committee or a member thereof, or the Plan itself. By participating in the Plan, or by asserting an entitlement to any right or benefit under the Plan, each Participant or beneficiary consents to the exercise of personal jurisdiction over him or her by the United States District Court for the Southern District of Indiana, Indianapolis Division, and waives any argument that that forum is not a convenient forum in which to resolve the lawsuit. In the unlikely event that the United States District Court for the Southern District of Indiana, Indianapolis Division lacks jurisdiction over a particular lawsuit, that lawsuit may be brought in any federal, state, or foreign court that does have jurisdiction. This Plan is governed by ERISA, and state law is generally preempted. To the extent state law applies, this Plan is governed by the laws of the State of Indiana, without giving effect to its conflict of law rules.

ARTICLE III

PARTICIPATION

3.1 **Participation.** An Employee will become a Participant as of the date he/she becomes an Eligible Employee.

3.2 **Enrollment Procedures.**

(a) Enrollment and Elections. A Participant can make a Plan Election, or change or revoke a Plan Election, by properly completing the designated enrollment form prescribed by the Plan Sponsor within an Election Period, subject to the following:

(1) Plan Election. The Plan Election must specify the taxable and non-taxable benefits elected by the Participant pursuant to the Plan, and if the Participant elects to establish a Health Care Flexible Spending Account, a Dependent Care Flexible Spending Account, or a Health Savings Account, it must specifically indicate the amounts to be credited to each such Account.

(2) Irrevocability. A Plan Election will be irrevocable after the last day of the Election Period in which it is filed, subject to the following:

(A) Special Election Periods for Medical Plan Coverage Only. The following are Special Election events that permit a change in the Covered Employee's elections under a Medical Plan for the remainder of the Plan Year. For purposes of this subsection (A) and the Change in Family Status events described herein, "dependent" refers to a "Dependent" as defined in the applicable Program Documents that offer medical coverage. For Medical Plans that offer dental or vision coverage, "Dependent" refers to a "dependent" as defined in the applicable Program Documents.

(i) Change in Family Status. The Change in Family Status events permit a Covered Employee to change his/her Plan Elections under the Medical Plan if the change is on account of and consistent with the Change in Family Status and the event affects the Covered Employee's or the Covered Employee's Spouse's or dependent's eligibility or possible eligibility for coverage under this Plan, a Medical Plan, or any other health care expense account, medical plan, dental plan, or other plan providing health coverage pursuant to Code § 105 that is sponsored by the Covered Employee's, Spouse's, or dependent's employer. In addition, if a Medical Plan provides dental or vision coverage, the following events shall also be considered to be a Change in Family Status event: a dependent of the Covered Employee becomes or

ceases to be eligible for coverage as a result of a change in marital, student, or tax dependency status.

(ii) Special Enrollment Rights. The Covered Employee may change his/her Plan Elections under the Medical Plan consistent with any special enrollment rights under the Health Insurance Portability and Accountability Act within the time period specified for such rights under the applicable Medical Plan.

(iii) Change in Other Coverage. The Covered Employee may change his/her Plan Elections if:

(I) A group Medical Plan or Section 125 cafeteria plan covering the Covered Employee's Spouse or dependent permits a change in health coverage at a time other than an Election Period under this Plan as a result of a Change in Family Status, a general enrollment period, or another coverage permitted by the Treasury Regulations;

(II) The Spouse or dependent elects a change in coverage; and

(III) The Covered Employee's change in coverage under this Plan is on account of and consistent with the change in the Spouse's or dependent's coverage.

(iv) Change in Cost or Coverage Options. An Election Period shall be deemed to have occurred, resulting in a new Plan Election for the remainder of the Plan Year, and an appropriate adjustment to the Covered Employee's Salary Reduction Amounts during the Plan Year (or commencement of Salary Reduction Amounts in an appropriate manner in the case of an Eligible Employee who had not previously elected to participate), in any of the following circumstances:

(I) The premium under any Medical Plan is significantly increased during the Plan Year and the Covered Employee elects to continue the existing coverage, elects coverage under another Medical Plan with similar coverage, or elects no Medical Plan coverage if no similar coverage is available.

(II) The premium under the Medical Plan is significantly decreased during the Plan Year and the Covered

Employee or Eligible Employee elects' coverage under that Medical Plan.

(III) The premium under any Medical Plan is increased or decreased during the Plan Year by an insignificant amount. (An automatic adjustment will occur in this case.)

(IV) The coverage under a Medical Plan is significantly curtailed during the Plan Year and the Covered Employee elects to receive on a prospective basis coverage under another plan with similar coverage.

(V) The coverage under a Medical Plan ceases during the Plan Year and the Covered Employee either elects to receive on a prospective basis coverage under another Medical Plan with similar coverage or elects no Medical Plan coverage if no similar coverage is available.

(VI) A new coverage option is added to a Medical Plan, or an existing coverage option is significantly improved, and the Covered Employee or Eligible Employee elects that new coverage option.

(v) Loss of Group Health Coverage Sponsored by a Governmental or Educational Institution. An Employee Participant may change his/her Plan Elections under the Medical Plan consistent with a loss of coverage by the Employee Participant or the Employee Participant's Spouse or dependent under any group health coverage sponsored by a governmental or educational institution.

(vi) FMLA. A Covered Employee taking leave under the FMLA may change his/her Medical Plan Elections as provided by that Act and applicable regulations or rulings thereunder.

(vii) Support Order. The Covered Employee (or the Plan if the Covered Employee does not take the required action) may add coverage in accordance with a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody that requires coverage for a Covered Employee's child or for a foster child who is a dependent of the Covered Employee. The Covered Employee may eliminate coverage for a child if a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody requires that coverage

of that child be provided by an individual other than the Covered Employee and that coverage is in fact provided.

(viii) Entitlement to Medicare or Medicaid. The Covered Employee may change his/her Plan Election consistent with a change in entitlement to Medicare or Medicaid (including a loss of entitlement) by the Covered Employee or the Covered Employee's Spouse or dependent.

(B) Special Election Periods for Health Care Flexible Spending Account. The following events that occur during the Plan Year are Special Election events that permit a change in the Covered Employee's Health Care Flexible Spending Account election for the remainder of the Plan Year, provided that any such election may not reduce the total amount to be credited to the Covered Employee's Health Care Flexible Spending Account for the Plan Year to less than the amount of eligible expenses incurred by the Covered Employee prior to the effective date of the new Plan Election. For purposes of this subsection (B) and the Change in Family Status events described herein, "dependent" refers to a "Dependent" as defined in Appendix A.

(i) Change in Family Status Events. The Change in Family Status events apply to allow a Covered Employee to change his/her Health Care Flexible Spending Account election if the change is on account of and consistent with the Change in Family Status and the event affects the Covered Employee's or the Covered Employee's Spouse's or dependent's eligibility or possible eligibility for coverage under this Plan, a Medical Plan, or any other health flexible spending account, medical plan, dental plan, or other plan providing health coverage pursuant to Code § 105 that is sponsored by the Covered Employee's, Spouse's or dependent's employer.

(ii) Support Order. The Covered Employee may increase coverage in accordance with a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody that requires coverage for a Covered Employee's child or for a foster child who is a dependent of the Covered Employee. The Covered Employee may decrease coverage if a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody requires that coverage of a child be provided by an individual other than the Covered Employee and that coverage is in fact provided.

(iii) Change in Medicare or Medicaid Entitlement. The Covered Employee may change his/her Plan Election consistent with a change in entitlement to Medicare or Medicaid (including a loss of entitlement) by the Covered Employee or the Covered Employee's Spouse or dependent.

(iv) FMLA. A Covered Employee taking leave under the FMLA may change his or her Plan Election as provided by that Act and applicable regulations or rulings thereunder.

(C) Special Election Periods for Dependent Care Flexible Spending Account. The following Change in Family Status events that occur during the Plan Year are special election events that permit a change in the Covered Employee's Dependent Care Flexible Spending Account election for the remainder of the Plan Year. For purposes of this subsection (C) and the Change in Family Status events described herein, "dependent" refers to a "Qualifying Individual" as defined in Appendix B.

(i) Change in Family Status Events. The Change in Family Status events also apply to allow a Covered Employee to change his/her Dependent Care Flexible Spending Account election if the change is on account of and consistent with the Change in Family Status and the event affects the Covered Employee's or the Covered Employee's Spouse's or dependent's eligibility or possible eligibility for coverage under this or any other dependent care plan pursuant to Code § 129 sponsored by the Plan Sponsor or the Covered Employee's, Spouse's, or dependent's employer.

(ii) Change in Other Coverage. The Covered Employee may change his/her dependent care election if:

(I) A Section 125 cafeteria plan covering the Covered Employee's Spouse or dependent permits a change in dependent care elections at a time other than an Election Period under this Plan as a result of a Change in Family Status event, a general enrollment period, or another change in coverage permitted by the applicable Treasury Regulations;

(II) The Spouse or dependent elects a change in coverage; and

(III) The Covered Employee's Change in Family Status under this Plan is on account of and consistent with the change in the Spouse's or dependent's coverage.

(iii) Change in Cost or Coverage Options. An Election Period shall be deemed to have occurred, resulting in a new Plan Election for the remainder of the Plan Year, and an appropriate adjustment to the Covered Employee's Salary Reduction Amounts during the Plan Year, if the cost of dependent care is significantly increased or decreased during the Plan Year by a dependent care provider who is not a relative of the Covered Employee and the Covered Employee either elects to continue the existing dependent care, elects a new provider, or elects not to have a dependent care provider.

(iv) FMLA. A Covered Employee taking leave under the FMLA may change his or her Plan Election as provided by that Act and applicable regulations or rulings thereunder.

(D) No Special Elections Needed to Change Health Savings Account Contributions. If permitted under Section 4.8(a), a Covered Employee may start or stop a Plan Election to contribute to a Health Savings Account or increase or decrease the Plan Election any time as long as the change is effective prospectively. Because the eligibility requirements and contribution limits for Health Savings Accounts are determined regularly as opposed to a Plan Year basis, no Special Election events are required to permit a change to a Covered Employee's Plan Election to contribute to a Health Savings Account.

(E) Additional Medical Plan Election Revocations. A Covered Employee may prospectively revoke his or her Plan Election for Medical Plan coverage that provides minimum essential coverage (as defined in Code § 5000A(f)(1)) if the conditions under either (i) or (ii) below are met:

(i) Conditions for Revocation due to Reduction in Hours of Service: The Covered Employee has a change in employment status so that he or she is reasonably expected to average fewer than 30 hours of service per week after the change, and the revocation of the Plan Election corresponds to the intended enrollment of the Covered Employee and any related individuals who cease coverage due to the revocation of the Plan Election, in another Medical Plan that provides minimum essential coverage and is effective no later than the first day of the second month following the month that includes the date the original Medical Plan coverage is revoked.

(ii) Conditions for Revocation due to Enrollment in Exchange Plan: The Covered Employee is eligible to enroll in a Qualified Health Plan (as defined in the Patient Protection and Affordable Care Act of 2010, as amended and the regulations and guidance issued thereunder ("ACA") § 1301(a)) through an Exchange (as defined in ACA § 1311) during a special enrollment period (under guidance issued by the Department of Health and Human Services or other applicable guidance) or during the Exchange's annual enrollment period, and the revocation of the Plan Election corresponds to the intended enrollment of the Covered Employee, and any related individuals who cease coverage due to the revocation of the Plan Election, in Medical Plan coverage through an Exchange which is effective no later than the day immediately following the last day of the revoked Medical Plan coverage.

(F) Other Special Election Events. Any Plan Election may be changed with respect to any Participating Program pursuant to any other event so recognized under applicable regulations under Code § 125.

(G) Consistency Requirement for Special Elections. Any such Plan Election during the period described above must be consistent with the Change in Family Status resulting from the event described above. The Plan Administrator will not accept any Plan Election during said Election Period which it deems to be inconsistent with the Change in Family Status. Furthermore, the Plan Administrator will not accept any Plan Election regarding credits to a Covered Employee's Health Care Flexible Spending Account which would reduce the total credits to the Account for the Plan Year below the lesser of the amount the Covered Employee has contributed to the Plan or the amount of benefit payments to the Covered Employee that have been made with respect to such Account previously during that Plan Year.

(3) Effective Dates. A Plan Election shall be deemed to have been filed on the date it is hand-delivered to the Plan Administrator, or if filed by mail, on the postmark date of such mailing, or if filed electronically, on the date and time stamp of the electronic filing.

A Plan Election filed during an Annual Election Period will be effective for each payroll period in the Plan Year to which the Plan Election relates (unless a new Plan Election is made in a Special Election Period occurring during the Plan Year). A Plan Election filed during any other Election Period will be effective as soon as administratively feasible following the date the Plan Election is properly received by the Plan Administrator or its designated agent (but not sooner than the first day of the coinciding or next

following payroll period) for each remaining payroll period in the Plan Year in which the Plan Election is filed (unless a new Plan Election is made during a Special Election Period or an Election Period for Health Savings Account contributions occurring during the Plan Year).

(4) Default Elections.

(A) Annual Election Period. If a Participant fails to file a Plan Election during an Annual Election Period, he/she will be deemed to have elected not to be covered under the Medical Plan, either type of Flexible Spending Account or Health Savings Account for the year.

(B) Initial Election Period. If a Participant fails to file a Plan Election during his/her Initial Election Period, he/she will be deemed to have made the following benefit elections:

(i) With respect to coverage under a Medical Plan, he/she will be deemed to have elected not to be covered under such Medical Plan as the Plan Administrator designates for this purpose.

(ii) With respect to coverage under the Health Care Flexible Spending Account or the Dependent Care Flexible Spending Account, he/she will be deemed to have elected not to be covered under either such account.

(iii) With respect to Health Savings Account contributions, if the Participant fails to take the necessary steps required to open a Health Savings Account, he/she will be deemed to have elected not to contribute to a Health Savings Account and will in turn not receive company contributions.

(C) Other Election Periods. If a Participant fails to file a Plan Election during any other Election Period, he/she will be deemed to have made the same Plan Elections as were in effect for him/her before the Election Period. In any case in which there was no prior benefit election in effect for a Participant, he/she will be deemed to have elected not to receive non-taxable benefits through the Plan.

(5) Leaves of Absence.

(A) Covered Employee Goes Leave of Absence That Lasts 31 or more Days. If a Covered Employee returns from a leave of absence during which he/she remains an Eligible Employee, and such leave ends:

(i) thirty-one (31) or more days following the start of such leave, the Covered Employee's Plan Election that was in effect when the absence began (or was made during a subsequent Election Period) will continue in effect during and upon return from the leave. For the Health Care Flexible

Spending Account, the Covered Employee's contribution amount for each remaining pay period in the Plan Year will be the contribution amount for each pay period in effect prior to the leave. In a subsequent Plan Year, the Covered Employee's Plan Election that was in effect when the absence began will not be reinstated upon the return from the leave. However, a return from the leave is a Change in Family Status that allows the Covered Employee to make a new Plan Election, which, if made, will apply for the remaining portion of the Plan Year. For the Dependent Care FSA and Health Savings Account, the Covered Employee's contribution amount for each remaining pay period in the Plan Year will be the contribution amount for each pay period in effect prior to the leave, unless and until the Covered Employee makes a subsequent change in contribution. In a subsequent Plan Year, the Covered Employee's Plan Election that was in effect when the absence began will not be reinstated upon the return from the leave. However, a return from the leave is a Change in Family Status that allows the Covered Employee to make a new Plan Election, which, if made, will apply for the remaining portion of the Plan Year. Any missed contributions for any Account that occurred during a leave due to not having sufficient funds in the paycheck to make the deposit will be collected at 50% contribution/deduction amount per pay upon return within same calendar year.

(B) Covered Employee Goes Leave of Absence That Lasts Fewer Than 31 Days.

(i) assuming the Covered Employee's coverage continued during such leave, the Covered Employee's Plan Election that was in effect when the absence began (or was made during a subsequent Election Period) will continue in effect upon return from the leave. For the Health Care Flexible Spending Account, the Covered Employee's contribution amount for each remaining pay period in the Plan Year will be the contribution amount for each pay period in effect prior to the leave. For the Dependent Care FSA and Health Savings Account, the Covered Employee's contribution amount for each remaining pay period in the Plan Year will be the contribution amount for each pay period in effect prior to the leave, unless and until the Covered Employee makes a subsequent change in Plan Election. In a subsequent Plan Year, the Covered Employee's Plan Election that was in effect when the absence began will not be reinstated upon the return from the leave. However, a return from the leave is a Change in Family Status that allows the Covered Employee to make a new Plan Election, which, if made, will

apply for the remaining portion of the Plan Year. Any missed contributions/deductions for any Account that occurred during a leave due to not having sufficient funds in the paycheck to make the deposit will be collected at 50% contribution/deduction amount per pay upon return within same calendar year.

(6) Rehires.

(A) Covered Employee Terminates Employment for Period that Lasts 31 or More Days or Spans Two Plan Years. If a Covered Employee's employment terminates and such Covered Employee is rehired as an Eligible Employee (i) thirty-one (31) or more days after the Covered Employee's original Termination of Employment or (ii) in a subsequent calendar year, the Covered Employee shall be treated as becoming an Eligible Employee again on the date the rehire occurred and a new Plan Election Period will be provided, except that the Election Period will not end earlier than thirty-one (31) days after the date the individual again became an Eligible Employee.

(B) Covered Employee Terminates Employment and is Rehired Within 30 Days and in Same Plan Year. If the Covered Employee is rehired in fewer than 31 days, any Plan Election that was in effect when the Covered Employee's employment terminated shall continue in effect until the next Election Period (with an appropriate adjustment of the amount reimbursable from the Covered Employee's Accounts to reflect any contributions not made by the Covered Employee during the period of absence). Any missed contributions/deductions for any Account that occurred during a leave due to not having sufficient funds in the paycheck to make the deposit will be collected at 50% contribution/deduction amount per pay upon return within same calendar year.

(7) Strike/Temporary Layoff

(A) Covered Employee Strike/Temporary Layoff Resulting in Discontinuation of Benefits that Lasts 31 or More Days or Spans Two Plan Years. If a Covered Employee's returns as an Eligible Employee (i) thirty-one (31) or more days after the Covered Employee's strike effective date or (ii) in a subsequent calendar year, the Covered Employee shall be treated as becoming an Eligible Employee again on the date the return to work occurred and a new Plan Election Period will be provided, except that the Election Period will not end earlier than thirty-one (31) days after the date the individual again became an Eligible Employee.

(B) Covered Employee Returns from Strike/Temporary Layoff Resulting in Discontinuation of Benefits Within 30 Days and in

Same Plan Year. If the Covered Employee returns to work in fewer than 31 days, any Plan Election that was in effect prior to strike for the Covered Employee shall continue in effect until the next Election Period (with an appropriate adjustment of the amount reimbursable from the Covered Employee's Accounts to reflect any contributions not made by the Covered Employee during the period of absence).

(b) Errors and Responsibility to Review. A Participant has a duty to promptly review enrollment notifications, paycheck information, and other communications that reflect enrollments and elections and to notify the Plan Administrator of any error that appears on such communications within thirty (30) days of the date such communication is provided or made available to the Participant or Beneficiary (for example, the date the paycheck is sent by mail, or the date a communication is provided or made available electronically). If a Participant fails to review any communication or fails to notify the Plan Administrator of any error that appears on such communication within such period of time, he/she will not be able to bring any claim seeking relief or damages based on the error.

3.3 **Cessation of Participation.** A Participant will remain such throughout the period he/she remains an Eligible Employee and continues to satisfy the terms and conditions of eligibility set forth in the applicable Program Documents. A Covered Dependent's participation in the Plan will terminate with respect to a Participating Program as set forth in the applicable Program Documents. Coverage under the Plan ends on the earliest of the following to occur: (1) the date the Participant elects not to participate in the Plan; (2) the last day of the Plan Year unless the Participant makes an election during the annual election period; (3) the date the Participant no longer satisfies the eligibility requirements; (4) the date the Participant terminates employment; or (5) the date the Plan is terminated. Coverage for a Dependent ends on the earliest of the following to occur: (1) the date the Participant's coverage ends; (2) the date the Dependent ceases to be eligible; or (3) the date the Plan is terminated.

If a Covered Employee ceases to be an Eligible Employee during the Plan Year, that will not prevent him/her from filing a claim for reimbursement of eligible expenses incurred during the portion of a Plan Year prior to the date on which he/she ceased to be an Eligible Employee, to the extent a balance then exists in his/her Account. Such a claim will be subject to the same rules as apply under this Plan to claims submitted after the end of a Plan Year by Covered Employees. In addition, a Covered Employee must continue to have his/her salary reduced for the full amount of his/her share of any premium or cost of any group coverage under a Medical Plan option.

ARTICLE IV

BENEFITS AND ACCOUNTS

4.1 **Benefits Available.**

(a) Elections. A Participant may elect under the Plan to receive one of the following taxable or non-taxable benefits:

(1) Taxable Compensation. A Participant can elect to receive the full amount of his/her compensation (as determined by his/her employer independent of the Plan) in cash; or

(2) Non-Taxable Benefits. A Participant can elect to receive a reduced level of compensation and in lieu thereof receive coverage under one or more of the following if he/she is eligible:

(A) The opportunity to make pre-tax premium payments under the Company's Medical Plans.

(B) Limited Purpose Health Care Flexible Spending Account.

(C) Dependent Care Flexible Spending Account.

(D) Contributions to a Health Savings Account.

(3) Deemed Election for Non-Taxable Benefits. A Participant who has elected group coverage under any Medical Plan option will be deemed to elect to have the Participating Employer pay on a pre-tax basis the Participant's share of any premium or cost required for such group coverage.

(b) Reduced Compensation in Exchange for Non-Taxable Benefits. If a Participant elects to receive the benefits specified in Section 4.1(a)(2) or (3), his/her compensation will be reduced each payroll period by his/her share of the cost (as determined by the Plan Sponsor independent of the Plan) for the coverage elected. A coverage election under any Participating Program must be made in accordance with the terms of such Participating Program.

(c) Participating Programs. The Program Documents for any Participating Program that the Plan Sponsor designates as being available through the Plan are hereby incorporated by reference into the Plan.

4.2 **Flexible Spending Account Coverage**

(a) Flexible Spending Accounts. If a Participant elects under the Plan to receive coverage under a Limited Purpose Health Care Flexible Spending Account and/or a Dependent Care Flexible Spending Account, the Plan Administrator will credit to such Account(s) such amount as the Participant has designated on his/her Plan Election, subject to the following:

(1) Flexible Spending Account Credits. The Plan Election will specify the dollar amount to be credited to each Account for each payroll period during the Plan Year (or the remaining portion of the Plan Year), and the compensation of the Covered Employee will be reduced in each payroll period by the sum of the dollar amounts for the payroll period to be credited to each Account.

(2) Debit Card for Limited Purpose Health Care Flexible Spending Account. If the Covered Employee elect's coverage under the Limited Purpose Health Care Flexible Spending Account, the Covered Employee may also elect to receive a Debit Card to be used for purchasing eligible Covered Health Care Expenses, subject to the following requirements:

(A) Covered Employee Certification. Prior to receiving a Debit Card, the Covered Employee must certify that:

(i) The Covered Employee will agree to abide by the terms and conditions of Debit Card use set forth in the Electronic Payment Cardholder Agreement (including any fees applicable to participate, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc.);

(ii) The Debit Card will only be used for the Covered Health Care Expenses of the Covered Employee and the Covered Employee's Spouse and dependents;

(iii) The Covered Employee will not use the Debit Card for Covered Health Care Expenses that have already been reimbursed;

(iv) The Covered Employee will not seek reimbursement under any other plan covering health benefits for Covered Health Care Expenses paid with the Debit Card; and

(v) The Covered Employee will acquire and retain sufficient documentation for any expense paid with the Debit Card, including invoices and receipts where appropriate.

(B) Specified Merchants, Service Providers, Merchant Codes. Use of the Debit Card must be limited to:

(i) Dentists, vision care offices, hospitals, and other medical care providers (as identified by merchant category code);

(ii) Stores with the merchant category code for Drugstores and Pharmacies if, on a location-by-location basis, 90 percent of the store's gross receipts during the prior taxable year consisted of items which qualify as expenses for medical care described in Code § 213(d) related to vision care or

dental care; and

(iii) Stores that have implemented the inventory information approval system (IIAS) approved by the IRS (as described in IRS Notice 2006-69, Prop. Treas. Reg. § 1.125-6(f), and any later applicable guidance).

(3) Timing/Limit on Limited Purpose Health Care Flexible Spending Account Credits. A Limited Purpose Health Care Flexible Spending Account will be credited immediately upon the effective date of a Plan Election with the full dollar amount specified by the Covered Employee to be credited to such Account for the Plan Year (or the remaining portion of the Plan Year). Credits to a Limited Purpose Health Care Flexible Spending Account for a Plan Year cannot be less than $250 or more than $3200 subject to annual IRS adjustment for inflation in accordance Code § 125 (or such other minimum and maximum amount established from time to time by the Plan Administrator, but in no event shall such maximum amount exceed the maximum amount set by law). The Plan Administrator will limit the Covered Employee as well as the Covered Employee's Spouse's and dependent's use of the Debit Card to the maximum dollar amount of coverage available in the Covered Employee's Health Care Flexible Spending Account.

(4) Timing/Limit on Dependent Care Flexible Spending Account Credits. A Dependent Care Flexible Spending Account will be credited in accordance with the Company's payroll schedule with a pro rata portion of the dollar amount specified by the Covered Employee to be credited to such Account for the Plan Year (or the remaining portion of the Plan Year). Credits to a Dependent Care Flexible Spending Account for a Plan Year cannot be less than $250 or more than $5,000 (or such lesser amount specified in Appendix B).

(5) Discontinuance of Credits. No amount will be credited to an Account, and the Plan Election will be deemed void, after the last day of the payroll period in which the Covered Employee ceases to be an Eligible Employee, except as provided in Section 4.6. The Debit Card is automatically cancelled upon the Covered Employee's Termination of Employment (or earlier, if the Covered Employee ceases to participate in the Health Care Flexible Spending Account prior to his/her Termination of Employment).

(6) Cancellation of Accounts. The balance of an Account will be forfeited by the Covered Employee and canceled as of the last day of the Plan Year or established grace period; *except that*, with respect to the Limited Purpose Health Care Flexible Spending Account, a Covered Employee shall be permitted to carry over to the immediately following Plan Year his or her available Carryover Amount. Any credit balance in excess of the Carryover Amount remaining after the expiration of the period for submitting claims for the Plan Year shall be forfeited. At the discretion of the Plan Administrator (or the representative of the Plan Administrator), such

forfeitures will be used to cover the administrative expenses of the Plan, be used to reduce required contributions for the following Plan Year, be returned on a reasonable and uniform basis to Covered Employees or be used as otherwise permitted under Code § 125 and the regulations issued thereunder. Experience gains may not be allocated to Covered Employees based on their individual claims experience.

(b) Accounts for Bookkeeping Purposes Only. Accounts are for bookkeeping purposes only. Any claim by a Participant against the Plan Sponsor or Participating Employer for benefits from an Account is that of a general creditor and is not secured. No assets relating to any Account are segregated from the other assets of the Plan Sponsor or Participating Employer, and no interest or other earnings will be credited to any Account.

4.3 **Payments Charged Against Accounts.**

(a) In General. A payment made under an Appendix to the Plan will be charged against the appropriate Account as of the date the payment is made (or, if earlier, as of the last day of the Plan Year in which the reimbursable expense is incurred). Benefits for eligible expenses incurred in one Plan Year may not be paid with amounts credited in another Plan Year.

(b) Debit Card for Limited Purpose Health Care Flexible Spending Account. If a Covered Employee uses the Debit Card, the merchant or service provider must be paid the full amount of the charge at the point-of-sale (assuming there is sufficient coverage available in the Health Care Flexible Spending Account), and the Covered Employee's maximum available coverage remaining must be reduced by that amount.

4.4 **Termination of Participation.** Any balance remaining in a Covered Employee's Accounts after he/she ceases to be a Covered Employee and after all benefits to which he/she is entitled have been paid will be forfeited and used as described in Section 4.2(a)(6).

4.5 **Payments Following a Covered Employee's Death.** The Plan Administrator will apply amounts credited to a deceased Covered Employee's Limited Purpose Health Care Flexible Spending Account for the Plan Year in which he/she dies to pay eligible expenses incurred during the portion of the Plan Year prior to death, subject to this Section 4.5. The Plan Administrator will apply amounts credited to a deceased Covered Employee's Dependent Care Flexible Spending Account for the Plan Year in which he/she dies to pay eligible expenses incurred during the Plan Year, whether incurred before or after death. Any amount remaining in the Accounts (after all eligible expenses have been reimbursed) as of April 15 of the Plan Year following death will be forfeited and used as described in Section 4.2(a)(6).

4.6 **Continuation Coverage.** The Plan will provide any continuation of coverage that may be required by COBRA or that may be required under USERRA, provided that the Covered Employee or other person receiving such coverage pays to the Plan Administrator or its designated agent, on an after-tax basis, 102% of the cost of any such coverage in effect following the qualifying event (or, if applicable, such lesser amount as may be the maximum allowed under USERRA). The Plan will also provide any continuation of coverage that may be required by the

FMLA, provided that the Covered Employee or other person receiving such coverage pays to the Plan Administrator, or its designated agent, the appropriate portion of the cost of that coverage pursuant to applicable federal regulations.

4.7 **Discrimination Prohibited.** The Plan will be operated in compliance with any applicable law or regulations regarding discrimination in favor of highly compensated individuals or key employees, including, but not limited to, the provisions of Code §§ 105(h), 125, and 129. The Plan Administrator reserves the right to impose limits on benefit availability or selection to the extent such limits are required to avoid such discrimination. In the event that elections by highly compensated employees for credits to a Dependent Care Flexible Spending Account would cause the limits of Code § 129 to be exceeded for a Plan Year, the Plan Administrator, or its designated agent, will reduce the credits for that year for such individuals, beginning with the highest dollar amount of credit, to the extent necessary to satisfy said limits. If a Covered Employee has already received benefits with respect to credits that are to be reduced pursuant to the previous sentence, such benefits will be treated as taxable income to the Covered Employee.

4.8 **Contributions to Health Savings Accounts.** If the Plan Sponsor determines in its sole discretion to implement subsection (a) and/or subsection (b) of this Section, the following provisions shall apply:

(a) Salary Reduction. A Participant who is eligible under Code § 223 to contribute to a Health Savings Account may elect to have the Participating Employer credit the Participant's Salary Reduction Amounts to a Health Savings Account.

(b) Participating Employer Contributions. The Participating Employer may make contributions through this Plan to the Health Savings Account of a Participant or class of Participants who are eligible under Code § 223 to contribute to a Health Savings Account.

The Program Documents governing the Health Savings Account, set forth the terms of such account (including the terms of Participating Employer contributions, if any, to such accounts).

4.9 **Unclaimed Self-Funded Plan Funds.** In the event that payments of benefits under a self-funded Participating Program made by check that is not cashed or deposited, or by electronic funds transfer or other payment method that is not deposited (for example, because the Participant cannot be located), shall remain in the Participating Employer's general assets and shall not escheat to the state, unless otherwise provided in the applicable administrative service agreement. Unless the Plan Administrator determines in its sole discretion that there are extenuating circumstances, the Plan's obligation to pay the benefit shall be extinguished if the check is not cashed or deposited, or electronic funds transfer or other payment is not deposited, within one (1) year after the date of the check, transfer, or other payment method and any benefits to which the check, electronic funds transfer, or other payment method relates will be forfeited.

ARTICLE V

ADMINISTRATION OF THE PLAN

5.1 **Administration.**

(a) Plan Administrator. The Plan Sponsor is the "Plan Administrator" of the Plan, with the authority to control and manage the operation and administration of the Plan and make all decisions and determinations incident thereto.

The Plan Sponsor hereby delegates its authority as the Plan Administrator and named fiduciary to any of the following:

(1) The Heritage Group Benefits Committee, in the case of matters relating to the overall and day-to-day administration of the Plan.

(2) Any individual, committee, or entity to the extent responsibility for the operation and administration of the Plan is allocated to such individual, committee, or entity by action of one of the above.

(b) Benefits Committee. The Heritage Group Benefits Committee, acting on behalf of the Plan Sponsor, shall be organized in accordance with, and will have such duties and responsibilities, and will act in such manner, as may be specified from time to time in the charter created for such committee, which is incorporated herein by reference. In the absence of a charter, the following shall apply:

The Benefits Committee of the Plan will consist of five individuals: two Plan officers and three individuals nominated and elected by participating employers. Three members of the Benefits Committee are nominated and elected by the participating employers:

(1) The Benefits Committee shall act by majority action with respect to matters consistent with the general responsibilities assigned to the committee in Section 5.1(a)(2).

(c) Claims Administrator. The Plan Administrator may from time-to-time contract with or appoint a Claims Administrator to assist the Plan Administrator in the handling of claims under any Participating Program. Any such recordkeeper or other third-party service provider will serve in a nondiscretionary capacity and will act in

accordance with directions given and/or procedures established by the Plan Administrator.

5.2 **Claims Procedure.**

(a) Claims Procedures. The Plan Administrator will establish a claims procedure for any Participating Program offered through the Plan (for example, for a medical expense reimbursement arrangement, dependent care expense reimbursement arrangement, Medical Plan) as a separate written document (which may be a section in the Summary Plan Description) that will be deemed to form a part of the Participating Program and is hereby incorporated by reference into the Plan.

(b) Time Limit for Lawsuits. The time limit for bringing any lawsuit that arises under or relates to this Plan or a Participating Program (other than claims for breach of fiduciary duty governed by ERISA § 413) is as follows:

(1) Exhaustion of Administrative Remedies Required. Before bringing any lawsuit seeking benefits under a Participating Program, a claimant must complete the claims procedure set out in the Participating Program (and comply with all applicable deadlines established as part thereof). Failure to properly exhaust the claims procedure will extinguish the claimant's right to file a lawsuit with respect to the claim.

(2) Time Limit. No action at law or in equity shall be brought to recover benefits under the Plan later than one year (or if earlier, the applicable time frame specified in the applicable Participating Program, or the date the applicable Indiana statute of limitations has or will run) from the date the claimant's final appeal has been denied, or if earlier, the date the claimant's administrative appeal rights have been exhausted.

5.3 **Verification/Substantiation of Expenses.**

(a) In General. The Plan Administrator may require a Covered Employee to verify expenses for which he/she is seeking payment or reimbursement in any manner that the Plan Administrator deems appropriate. The Plan Administrator may also provide for automatic submission of claims filed with any insurance company or service provider to the extent such claims are not covered by the Participating Program. The Plan Administrator has the discretionary authority to review expenses submitted for reimbursement and to make the final decision whether a particular benefit claim is eligible for reimbursement under the Plan, or the Plan Administrator may delegate such questions to a Claims Administrator or other service provider. Notwithstanding the foregoing, the rules governing payment of claims from Health Savings Accounts are set forth in the Program Documents governing such accounts.

(b) Covered Employee of Debit Card Purchases. The Plan Administrator will substantiate claimed Covered Health Care Expenses after the use of the Debit Card based on the type of transaction:

(1) IIAS-Approved Transactions. The Plan Administrator will permit automatic reimbursement, without further review, of Covered Health Care Expenses substantiated through the inventory information approval system (IIAS) approved by the IRS.

(2) Certain Specified Providers. For the providers described in subsections 4.2(a)(2)(B)(i) and (ii), the Plan Administrator will substantiate claimed Covered Health Care Expenses in the following manner:

(A) Co-Payment Transactions. If the dollar amount of the transaction at a health care provider equals an exact multiple of the dollar amount of the co-payment for that service under the Medical Plan of the employee-cardholder, the Plan Administrator will consider the charge to be fully substantiated without the need for submission of a receipt or further review.

(B) Real-Time Transactions. If a merchant, service provider, or other independent third-party at the time and point-of-sale, provides information to verify to the Plan Administrator (including electronically by email, the internet, intranet, or telephone) that the charge is for a Covered Health Care Expense, the Plan Administrator will consider the charge to be fully substantiated without the need for submission of a receipt or further review.

(C) All Other Transactions. The Plan Administrator will treat all transactions other than co-payment and real-time transactions as described above (and IIAS-approved transactions as described in subsection (1) above) as conditional pending confirmation of the charge. The Plan Administrator requires the Covered Employee to submit additional third-party information, such as merchant or service provider receipts, describing: (i) the service or product, (ii) the date of service or sale, and (iii) the amount.

(c) Compliance with IRS Guidance. The Plan Administrator will comply with any IRS guidance issued regarding the Covered Employee of claimed Covered Health Care Expenses, including but not limited to, IRS Notice 2011-5 and any later applicable guidance.

5.4 **Correction of Errors.**

(a) In General. Errors may occur in the operation and administration of the Plan. The Plan Administrator reserves the power to cause such adjustments to be made to correct for such errors as it considers appropriate. Such adjustments will be final and binding on all persons. Such adjustment includes the right to recoup an erroneous overpayment.

(b) Debit Card Purchases. If claims that have been reimbursed through the use of the Debit Card are subsequently identified as not qualifying for reimbursement, the Plan Administrator will take the following steps:

(1) Until the improper payment is recovered, the Debit Card will be de-activated, and the Covered Employee must request payments or reimbursements of Covered Health Care Expenses from the Limited Purpose Health Care Flexible Spending Account through other methods;

(2) The Plan Administrator will require the Covered Employee to pay back to the Plan an amount equal to the improper payment;

(3) If requiring the Covered Employee to pay the Plan back proves unsuccessful, the Plan Administrator will withhold the amount of the improper payment from the Covered Employee's wages or other compensation to the extent consistent with applicable law;

(4) If the improper payment remains outstanding, the Plan Administrator will utilize a claims substitution or offset approach to resolve the impending claim; and

(5) If the correction efforts described in this subsection prove unsuccessful so that the Covered Employee remains indebted to the Plan Administrator for the amount of the improper payment, the Plan Administrator will treat the payment as the Plan Administrator would any other business indebtedness.

5.5 **Indemnification.** The Plan Sponsor, to the maximum extent permitted by law, its corporate charter, and its bylaws, shall indemnify and hold harmless, directly from its own assets (including the proceeds of any liability insurance policy the premiums of which are paid from the Plan Sponsor's own assets), the Board and any employee, officer, or shareholder of the Plan Sponsor from and against all loss, damages, liability, and reasonable costs and expenses incurred in carrying out his or her responsibilities under the Plan, unless due to the bad faith, willful misconduct, or dishonest acts of such person, provided that such individual's attorney's fees and any amount paid in settlement shall be approved by the Plan Sponsor.

In the event of the sale of an Affiliate, or substantially all of the assets of an Affiliate, joint and several liability hereunder will not extend to the Affiliate or purchaser of the assets of the Affiliate, beyond the sale unless liability is expressly assumed as part of the sale transaction. This indemnification is in addition to any other indemnification expressly given by the Plan Sponsor.

5.6 **Exercise of Authority.** The Plan Sponsor, its chief executive officer, the Heritage Group Benefits Committee, and any other person who has authority with respect to the management or administration of the Plan may exercise that authority in his/her full discretion, subject only to the duties imposed under ERISA. This discretionary authority includes, but is not limited to, the authority to make any and all factual determinations and interpret all terms and provisions of this document (or any other document established for use in the administration of the Plan or any Participating Program offered through the Plan) relevant to the issue under consideration. The exercise of authority will be binding upon all persons, and it is intended that

the exercise of authority be given deference in all courts of law to the greatest extent allowed under law, and that it not be overturned or set aside by any court of law unless found to be arbitrary and capricious.

5.7 **Telephonic or Electronic Notices and Transactions.** Any notice that is required to be given under the Plan to a Participant, and any action that can be taken under the Plan by a Participant (including enrollments, changes in elections, consents, etc.), may be by means of voice response or other electronic system to the extent so authorized by the Plan Administrator and permitted under the Code.

5.8 **HIPAA.** The provisions set forth below apply to the Plan only to the extent that the Plan or any Participating Program constitutes a "health plan" under 45 C.F.R. § 160.103 that uses or discloses "protected health information" ("PHI") or "electronic protected health information" ("ePHI") as those terms are defined in the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§ 160 and 164, as amended from time to time, including without limitation as amended by the Health Information Technology for Economic and Clinical Health Act, part of the America Recovery and Reinvestment Act of 2009, (the "HIPAA Privacy Rules") and 45 C.F.R. §§ 160, 162 and 164, as amended from time to time (the "HIPAA Security Rule"). For purposes of this Section 5.8, terms defined in the HIPAA Privacy Rules and the HIPAA Security Rule, but not in this Plan, shall be interpreted and administered in accordance with those provisions and the term "Plan" shall be interpreted to include this Plan and the Participating Programs to which this Section 5.8 applies.

(a) Permitted Uses and Disclosures. In accordance with the HIPAA Privacy Rules, a Participating Program may disclose PHI to the Participating Employer in order for the Participating Employer to carry out Plan administration functions that the Participating Employer performs consistent with the provisions of subsections (1) and (2) below.

A Participating Program may not:

(1) disclose or permit an insurance company, insurance service, insurance organization, or HMO to disclose PHI to the Participating Employer unless the HIPAA Privacy notice covering the Participating Program contains a statement describing such disclosure; or

(2) disclose PHI to the Participating Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Participating Employer, unless otherwise authorized by the individual who is the subject of the PHI or required by the HIPAA Privacy Rules.

(b) Conditions of Disclosure. A Participating Program may disclose PHI to the Participating Employer as described in this Section 5.8(b) only upon receipt of a certification by the Participating Employer that the Participating Program has been amended to incorporate the following provisions and only if the Participating Employer agrees to:

(1) Not use or further disclose the PHI other than as permitted or required by the Participating Program's controlling documents or as required by law;

(2) Ensure that any agents to whom it provides PHI shall agree to the same restrictions and conditions that apply to the Participating Employer with respect to such PHI;

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

(4) Report to the Participating Program any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided herein, if and when the Participating Employer becomes aware of such inconsistent use or disclosure;

(5) Authorize the Participating Program to make PHI available to individuals, in accordance with HIPAA Privacy Rules and consistent with the HIPAA Privacy policy applicable to the Participating Program;

(6) Authorize the Participating Program to make PHI available to individuals for amendment and to incorporate into PHI any such amendments, in accordance with the HIPAA Privacy Rules and consistent with the HIPAA Privacy policy applicable to the Participating Program;

(7) Authorize the Participating Program to make available the information required to provide an accounting of disclosures, in accordance with the HIPAA Privacy Rules and consistent with HIPAA Privacy policy applicable to the Participating Program;

(8) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Participating Program available to the Secretary of Health and Human Services for purposes of determining the Participating Program's compliance with the HIPAA Privacy Rules;

(9) If feasible, return or destroy all PHI that the Participating Employer received from the Participating Program and which the Participating Employer no longer needs for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Participating Employer shall limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(10) Ensure that the adequate separations described in subpart (c) below are established.

(c) Adequate Separations. The Participating Employer shall ensure that the following adequate separations are established between the Participating Program and the Participating Employer:

(1) Only the following persons under the control of the Participating Employer shall be given access to PHI: employee benefits personnel at the Plan Sponsor's corporate headquarters, employees in the Plan Sponsor's corporate legal department, information technology representatives whose job responsibilities include designing and supporting the computer systems used in administering the Plans, and members of the Board (the "Group");

(2) Access to and use of PHI by the Group shall be restricted to the Plan administration functions that the Participating Employer performs for the Participating Program; and

(3) Non-compliance by the Group shall be resolved by applying the disciplinary measures specified in the Participating Program's HIPAA Privacy sanctions procedures.

(d) Security of Electronic Protected Health Information. In accordance with the Security Rules, the Participating Employer agrees to reasonably and appropriately safeguard ePHI created, received, maintained, or transmitted to or by the Participating Employer on behalf of the Participating Program and shall:

(1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that it creates, receives, maintains, or transmits on behalf of the Participating Program;

(2) Ensure that the separations described in Section 5.8(c) above are supported by reasonable and appropriate security measures;

(3) Ensure that any agent to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect ePHI; and

(4) Report to the Participating Program any security incident of which it becomes aware.

(e) Insured Participating Programs. For "insured" Participating Programs, HIPAA compliance is the responsibility of the Insurance Carrier and nothing in this Section 5.8 is intended to change that result.

ARTICLE VI

AMENDMENT OR TERMINATION

6.1 **Amendment.** The Plan Sponsor expressly reserves the right to amend the Plan in whole or in part at any time and from time to time (including the power to amend, modify, or terminate any Participating Program, to replace any Claims Administrator or Insurance Carrier, and to add or remove any Participating Employer). An amendment may be adopted:

(a) By resolution of the Board.

(b) By signed writing of the chair of the Heritage Group Benefits Committee.

(c) By signed writing of any person to whom amendment authority has been delegated by action of one of the above.

No action by any person or body with amendment authority will constitute an amendment to the Plan unless it is expressly designated as an amendment to the Plan.

6.2 **Termination.** The Plan Sponsor may terminate the Plan at any time and for any reason by action of its Board. Termination of the Plan may not deprive a Participant of the right to have the balance credited to his/her Accounts as of the date of the Plan's termination paid in accordance with the terms of the Plan.

ARTICLE VII

MISCELLANEOUS

7.1 **Non-Alienation of Benefits.** Except as otherwise required by the Plan, the Program Documents, or applicable law, no Participant, beneficiary, or any other person shall have the right to assign, transfer, alienate, mortgage, pledge, or otherwise encumber any benefit or right provided under any Participating Program, or any benefit or right provided by ERISA related to any Participating Program (including the right to file claims or appeals and the right to bring a lawsuit seeking benefits, penalties, damages, or equitable relief) to any person (including but not limited to providers of benefits). Any such attempted disposition thereof shall be void. Benefits under a Participating Program will not be subject to attachment, garnishment, execution, or levy of any kind (either voluntary or involuntary). *Notwithstanding the above*:

(a) The Claims Administrator may elect to pay benefits directly to a provider of benefits; however, the payment of benefits directly to a provider of benefits, if at all, shall be done as a convenience to the Participant or beneficiary. Any payment by the Claims Administrator to a provider of benefits shall not constitute an assignment of benefits or an assignment of any other rights under the Plan.

(b) In the case of any Participating Program that is a "group health plan" within the meaning of ERISA § 607, this provision will not prevent payments to a child or the custodial parent or legal guardian of a child made pursuant to a QMCSO.

(c) In the case of any Participating Program that is a "group health plan" within the meaning of ERISA § 607, this provision will not prevent payments from being made in accordance with any assignment of rights made by or on behalf of an individual that is required under any state law governing Medicaid; and, to the extent that an individual receives benefits under Medicaid under circumstances where the Participating Program has a legal liability to make payments for medical care, such payments will be made in accordance with any state law governing Medicaid that provides that the state has acquired a right to such payments.

(d) In addition, all benefits payable under any Participating Program are subject to set-off for debts owed by the Participant to the Plan Sponsor, or an Affiliate to the extent permitted by law.

7.2 **No Guarantee of Employment.** The Plan is not an employment agreement, and participation herein does not constitute a guarantee of employment with the Participating Employer or any Affiliate.

7.3 **Plan Benefits Are Unsecured.** No Participant will, by virtue of the Plan, have any interest in any specific asset or assets of the Participating Employer or any Affiliate. A Participant has only an unsecured contractual right to receive payments in accordance with the Plan.

7.4 **Liability for Insured Benefits.** In any case in which benefits under the Plan are to be provided by an insurance carrier, health maintenance organization, or similar entity, the sole obligation of the Plan Sponsor and its Affiliates under the Plan is to apply for the coverage and

transmit the premiums to the carrier to the extent such premiums are paid by the Participant. Neither the Plan Sponsor or its Affiliates, nor any officer, director, employee, or agent thereof, will have any liability to a Participant or the Participant's dependents for any losses or damages related to the refusal of a carrier to issue a policy or other contract, the cancellation of a contract by the carrier, the denial of a claim for benefits by a carrier, or the inability of a carrier to pay benefits when due.

7.5 **Tax Consequences.** The Plan Sponsor does not make any representation or guarantee to any Participant or dependent that any amounts deducted from a Participant's pay or benefits paid under this Plan will be excludable from his/her gross income for federal or state income or other tax purposes, or that any particular federal or state tax treatment will apply to the Participant. Each Participant is solely responsible for determining whether payments under this Plan are excludable from his/her gross income for federal and state income tax purposes, and will notify the Plan Sponsor, or its designated agent, if he/she has reason to believe that any such payment is not excludable.

7.6 **Effect on Other Benefit Programs.** For purposes of other benefit programs maintained by the Plan Sponsor, a Participant's compensation will be considered the amount payable to the Participant before his/her compensation is reduced in accordance with the provisions of this Plan, unless the other benefit program specifically provides a contrary result.

7.7 **Severability of Provisions.** If any provision of the Plan is held illegal or invalid for any reason, such illegality or invalidity will not affect the remaining provisions of the Plan, but the Plan will be construed and enforced as if such illegal or invalid provision had never been inserted herein.

7.8 **Construed as a Whole.** The Plan is to be construed as a whole in such manner as to carry out its purpose and a given provision is not to be construed separately without relation to the context.

7.9 **Headings.** Headings at the beginning of Articles and Sections are for convenience of reference, are not considered a part of the text of the Plan and will not influence its construction.

The Heritage Group Cafeteria Plan is hereby adopted by the Company effective January 1, 2025.

The Heritage Group

By:_ Bobby McCaw _____

Title: EVP People + Culture_____

ATTEST:

By:_____ Stephen Kan _____

Title: Director, Benefits and Well-Being Strategy_____

APPENDIX A

LIMITED PURPOSE HEALTH CARE FLEXIBLE SPENDING ACCOUNT

A.1 Introduction. This Appendix is intended to qualify as an accident or Medical Plan under Code §§ 105 and 106 and should be interpreted consistent with such intent.

A.2 Definitions.

(a) "Dependent" means an individual defined as such in Code § 105(b) and also includes any child (as defined in Code § 152(f)(1)) of a Covered Employee who has not yet reached age 26 (unless a narrower definition is adopted by the Plan Sponsor).

(b) "Covered Health Care Expense" means any expense for vision care or dental care as allowed under Code § 223(c)(1)(B), but not including any of the following:

(1) Insurance premiums of any sort; and

(2) Any expense in a category of expenses excluded by the Plan Administrator.

For purposes of this Appendix, an expense is considered to be "incurred" when the services giving rise to the expense are rendered or, in the case of the purchase of a product, as of the date of such purchase.

A.3 Eligibility. A Covered Employee may elect to participate in a Limited Purpose Health Care Flexible Spending Account as described in this section.

A.4 Benefits and Limitations. A Covered Employee is entitled to reimbursement from his/her Limited Purpose Health Care Flexible Spending Account for Covered Health Care Expenses incurred during the Plan Year on behalf of the Covered Employee or his/her Spouse or any Dependent, subject to the following:

(a) A Covered Employee is not entitled to reimbursement for Covered Health Care Expenses incurred during a Plan Year to the extent such expenses are reimbursed or reimbursable under a Medical Plan, other insurance, or from some other source.

(b) A Covered Employee is not entitled to reimbursement for Covered Health Care Expenses incurred during a Plan Year prior to the date he/she becomes a Covered Employee. A Covered Employee who ceases to be an Eligible Employee during the Plan Year is not entitled to reimbursement for Covered Health Care Expenses incurred during the Plan Year after he/she ceases to be an Eligible Employee.

(c) A Covered Employee is not entitled to reimbursement for Covered Health Care Expenses incurred during a Plan Year to the extent that such expenses exceed the amount then credited to his/her Limited Purpose Health Care Flexible Spending Account (which will be the amount previously credited under Section 4.2 reduced

by the amounts previously charged under Section 4.3). If a Covered Employee takes a leave of absence under the FMLA, revokes coverage under the Health Care Flexible Spending Account at the start of such leave, and elects to reinstate coverage upon return from such leave within the same Plan Year, the amount deemed to have been credited to his/her Limited Purpose Health Care Flexible Spending Account upon reinstatement of coverage will be prorated for the period during the leave for which no premiums were paid by the Covered Employee.

(d) Except to the extent permitted in Section A.5 concerning Carryover Amounts, a Covered Employee is not entitled to reimbursement for Covered Health Care Expenses incurred during a Plan Year to the extent that such expenses exceed $3200 (subject to annual adjustments for inflation in accordance with Code § 125 or such other maximum amount established from time to time by the Plan Administrator, but in no event shall such maximum amount exceed the maximum amount set by law).

(e) A Covered Employee is not entitled to reimbursement for Covered Health Care Expenses incurred during a Plan Year by his/her Spouse after dissolution of marriage or by his/her Dependent after ceasing to qualify as a Dependent, unless such individual is entitled to elect continued coverage, makes such an election, and pays 102% of the cost of such coverage in accordance with COBRA.

(f) A Covered Employee is not entitled to reimbursement for Covered Health Care Expenses incurred during a Plan Year if the claim for such reimbursement is not filed in accordance with such procedures and by such deadlines provided under Section A.7.

A Covered Employee who requests a qualified reservist distribution pursuant to Section A.6 below will no longer be allowed to submit expenses for reimbursement under this section.

A.5 <u>Carryover Feature</u>. A Covered Employee shall be permitted to carry over to the immediately following Plan Year his or her available Carryover Amount. Any credit balance in excess of the Carryover Amount remaining after the expiration of the period for submitting claims for the Plan Year shall be forfeited. Amounts carried over to a Covered Employee's Limited Purpose Health Care Flexible Spending Account for a Plan Year shall be in addition to Employee contributions made for that Plan Year.

A Covered Employee's unused credit balance in his or her Limited Purpose Health Care Flexible Spending Account at the end of a Plan Year may be used (i) for expenses incurred in that Plan Year, but only if claimed before the date specified in Section A.7, or (ii) to the extent of the permitted Carryover Amount, for expenses that are incurred at any time in the subsequent Plan Year.

The Plan shall treat reimbursements of all Limited Purpose Health Care Flexible Spending Account claims for expenses that are incurred in a Plan Year as reimbursed first from unused amounts credited for that Plan Year and, only after exhausting such Plan Year amounts, as then reimbursed from the Carryover Amount.

A.6 Qualified Reservist Distributions. A Covered Employee who:

(a) Is a member of a military service unit (as defined in 37 U.S.C. § 101) ordered or called to active duty for a period of at least 180 days or for an indefinite period,

(b) Requests a qualified reservist distribution during the period beginning on the date the Covered Employee is called to active duty and ending on the last day of the Plan Year, in which the Covered Employee was called to duty, and provides the Plan Administrator with a copy of the order or call to duty, will receive a qualified reservist distribution within a reasonable time after proof, as specified in paragraph (c), is received by the Plan Administrator, but no later than sixty (60) days after such request, equal to the amount credited to his/her Health Care Flexible Spending Account as of the date of such request (which will be the amount previously credited under Section 4.2 reduced by the amounts previously charged under Section 4.3). A Covered Employee who requests a qualified reservist distribution will no longer be allowed to submit expenses for reimbursement under Section A.4.

A.7 Claim Deadline. A claim for reimbursement of Covered Health Care Expenses incurred during the Plan Year must be filed by March 31 following the end of the Plan Year (or such earlier deadline as may be established by the Plan Administrator). For a Plan Year in which the Participant's employment is terminated, any claims for reimbursement must be filed within 90 days of the date of such termination. Each Participant must submit an expense for reimbursement and provide the required substantiation in accordance with the procedures established by the Plan Administrator.

A.8 Repayment of Excess Reimbursements. If, as of the end of any Plan Year, it is determined that a Participant received payments under the Limited Purpose Health Care Flexible Spending Account that exceeded the amount of Covered Health Care Expenses that have been substantiated by such Participant during the Plan Year or reimbursements have been made in error, the Plan Administrator shall recoup the excess reimbursements in one or more of the following ways: (1) the Plan Administrator shall give the Participant prompt written notice of any such excess amount and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification; (2) the Plan Administrator may offset the excess reimbursement against any other Covered Health Care Expenses submitted for reimbursement (regardless of the Plan Year in which submitted); (3) the Plan Administrator shall withhold such amounts from the Participant's pay (to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursement through the means set forth above, the Plan Administrator will notify the Employer that the funds could not be recouped, and the Employer will treat the excess reimbursement as it would any other business debt.

APPENDIX B

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

B.1 Purpose. This Appendix is intended to qualify as a dependent care assistance program under Code § 129 and should be interpreted consistent with such intent.

B.2 Definitions.

(a) "Dependent," with respect to a Covered Employee, mean an individual defined as such in Code § 152 (unless a narrower definition is adopted by the Plan Administrator).

(b) "Dependent Care Center" means any facility outside the Covered Employee's household that receives a fee, payment, or grant for providing services for any of the individuals (regardless of whether the facility is operated for profit) and provides care for more than 6 individuals (other than individuals who reside at the facility).

(c) "Covered Dependent Care Expense" means any "employment-related" expense defined as such under Code § 21(b)(2) that is incurred by the Employee while he/she is a Covered Employee with one or more Qualifying Individuals, generally including the following:

(1) An expense incurred for services provided within the Covered Employee's household for household services or for the care of a Qualifying Individual.

(2) An expense incurred for services provided outside the Covered Employee's household for the care of a Qualifying Individual who is either (i) a Type A Qualifying Individual or (ii) a Type B Qualifying Individual who regularly spends at least 8 hours a day in the Covered Employee's household.

An expense incurred for services provided outside the Covered Employee's household by a Dependent Care Center that provides care for more than six individuals (excluding individuals who reside there) will be included as an "Covered Dependent Care Expense" only if the Dependent Care Center complies with all applicable state and local laws and regulations.

For purposes of this Appendix:

(3) An expense is considered to be "incurred" when the services giving rise to the expense are rendered.

(4) "Employment-related" means incurred to enable the Covered Employee to be gainfully employed. In the case of a married Covered Employee, the expense must also enable the Covered Employee's Spouse to be gainfully employed, actively seek gainful employment, or be a full-time student, unless the Spouse is physically or mentally disabled.

(5) "Household services" means services ordinarily necessary to maintain a Covered Employee's home and rendered as part of a Qualifying Individual's care.

(6) "Care" means services primarily to assure the well-being and protection of a least one Qualifying Individual.

(d) "Qualifying Individual" means an individual defined as such under Code § 21(b)(1) and includes:

(1) "Type A Qualifying Individual" means a Dependent who is under age 13 and with respect to whom a Covered Employee is entitled to an "exemption" deduction under Code § 151the.

(2) "Type B Qualifying Individual" means a Dependent (other than a Type A Qualifying Individual) or Spouse of the Covered Employee who is physically or mentally incapable of caring for himself or herself.

B.3 Eligibility. The Employees eligible to establish a Dependent Care Flexible Spending Account are all benefit eligible employees.

B.4 Benefits and Limitations. A Covered Employee is entitled to reimbursement from their Dependent Care Flexible Spending Account for Covered Dependent Care Expenses incurred during the Plan Year, subject to the following:

(a) A Covered Employee is not entitled to reimbursement for Covered Dependent Care Expenses incurred during a Plan Year prior to the date he/she becomes a Covered Employee.

(b) A Covered Employee who ceases to be an Eligible Employee during the Plan Year is not entitled to reimbursement for Covered Dependent Care Expenses incurred during the Plan Year after he/she ceases to be an Eligible Employee; provided, however, that if a Covered Employee dies while participating in the Dependent Care Flexible Spending Account, Covered Dependent Care Expenses incurred after the death within the Plan Year in which he/she dies may be reimbursed up to the amount remaining in the Dependent Care Flexible Spending Account for that Plan Year.

(c) A Covered Employee is not entitled to reimbursement for Covered Dependent Care Expenses incurred during a Plan Year in excess of the amount then credited to his/her Dependent Care Flexible Spending Account (which will be the amounts previously credited under Section 4.2 reduced by the amounts previously charged under Section 4.3). If a Covered Employee claims a benefit in excess of the amount, then credited to such Account, the excess amount may in the discretion of the Plan Administrator be paid from amounts subsequently credited to such Account during the same Plan Year.

(d) A Covered Employee is not entitled to reimbursement for Covered Dependent Care Expenses incurred during a Plan Year to either of the following individuals for dependent care services rendered by such individual:

(1) Any child of the Covered Employee who has not attained age 19 as of the close of the Plan Year in which the child performed services, or

(2) Any Dependent with respect to whom a deduction under Code § 151(c) is allowable to the Covered Employee or his/her Spouse for the Plan Year in which the services are performed.

(e) A Covered Employee is not entitled to reimbursement for Covered Dependent Care Expenses incurred during a Plan Year to the extent that such expenses exceed the lesser of $5,000 ($2,500 in the case of a Covered Employee who is a married individual filing a separate return) or the earned income limitation specified in Code § 129(b). A Covered Employee who is married is not entitled to reimbursement until he/she provides what the Plan Administrator considers to be satisfactory proof of the earned income of his/her Spouse and his/her federal income tax filing status.

(f) A Covered Employee is not entitled to reimbursement for Covered Dependent Care Expenses incurred during a Plan Year if the claim for such reimbursement is not filed in accordance with such procedures or by such deadlines provided under Section B.5.

B.5 Claim Deadline. A claim for reimbursement of Covered Dependent Care Expenses incurred during the Plan Year must be filed by March 31 following the end of the Plan Year (or such earlier deadline as may be established by the Plan Administrator). Each Participant must submit an expense for reimbursement and provide the required substantiation in accordance with the procedures established by the Plan Administrator.

B.6 Repayment of Excess Reimbursements. If, as of the end of any Plan Year, it is determined that a Participant received payments under the Dependent Care Flexible Spending Account that exceeded the amount of Covered Dependent Care Expenses that have been substantiated by such Participant during the Plan Year or reimbursements have been made in error, the Plan Administrator shall recoup the excess reimbursements in one or more of the following ways: (1) the Plan Administrator shall give the Participant prompt written notice of any such excess amount and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification; (2) the Plan Administrator may offset the excess reimbursement against any other Covered Health Care Expenses submitted for reimbursement (regardless of the Plan Year in which submitted); (3) the Plan Administrator shall withhold such amounts from the Participant's pay (to the extent permitted under applicable law). If the Plan Administrator is unable to recoup the excess reimbursement through the means set forth above, the Plan Administrator will notify the Employer that the funds could not be recouped, and the Employer will treat the excess reimbursement as it would any other business debt.

APPENDIX C

HEALTH SAVINGS ACCOUNT

D.1 Purpose. This Appendix is intended to describe the Health Savings Account feature of the Plan under Code §223 and should be interpreted consistent with such intent.

D.2 Eligibility. An Employee is eligible to participate in the Health Savings Account (the HSA) feature of the Plan if he/she has coverage under a qualifying High Deductible Health Plan (a group health plan as described in Code § 223(c)(2)) sponsored by the Plan Sponsor and he/she meets the eligibility requirements set forth in the SPD for the Plan and/or the separate documents governing the HSA.

D.3 Employer Contributions. The Employer shall contribute such amounts (if any), as determined by the Plan Administrator with respect to the Employer's Employees, to each Employee's Health Savings Account. All Employer contributions under this section are nonforfeitable when made.

D.4 Maternity and Prescription Drug Grant Programs. In addition to any Employer contributions made in accordance with D.3, the Employer will offer Participants the opportunity to receive certain additional HSA contributions as follows:

(a) The Employer will contribute an extra $2,000 (the "maternity grant"), or such other amount as determined by the Benefits Committee and communicated to Participants from time to time, to the Health Savings Account of a qualifying Participant to help offset the costs of the prenatal journey and delivery of a newborn. To be eligible for the maternity grant, an Employee must be a regular, full-time, benefits-eligible employee, enrolled in a High Deductible Health Plan sponsored by the Employer, and meet any other eligibility requirements established by the Employer.

(b) The Employer will make a one-time contribution (the "prescription drug grant") to a Participant's HSA, in an amount designated by the Benefits Committee and communicated to Participants from time to time, to help offset the cost of certain high-cost prescription medications. To be eligible for the prescription drug grant, an Employee must be a regular, full-time, benefits-eligible employee, enroll in a High Deductible Health Plan sponsored by the Employer, and meet any other eligibility requirements established by the Employer. The prescription drug grant is a one-time benefit and may not be renewed.

D.5 Participant Regular Contributions. An Employee may make an election to make monthly contributions to his or her Health Savings Account. The amount contributed by a Participant shall not exceed the annual amount determined under Code §223(b)(2) less the annual Employer contribution under D.4.

D.6 Participant Catch-Up Contributions. A Participant (a) who is eligible to make contributions under the Plan and (b) who is or will be age 55 or older on December 31 of a Plan

Year may make an election under the Plan to make additional before-tax monthly contributions to his or her Health Savings Account. The amount contributed by a Participant pursuant to this section with respect to any month shall not exceed the amount determined in Code § 223(c)(2).

D.7 Remittance to Trust. The Employer shall transmit all contributions made under this Appendix D to the HSA Trustee who shall be responsible for holding such amounts and administering the Health Savings Account in accordance with the trust or custodial agreement entered into between the Participant and the HSA Trustee.

D.8 Status of Health Savings Account. The Participant (and not the Employer) is the owner of the Health Savings Account to which the Participant's and the Employer's contributions are transmitted. The Employer shall have no responsibility or liability with respect to the Health Savings Account including, but not limited to, determinations regarding investment of amounts held in the Health Savings Account and distributions from the Health Savings Account. This Appendix C is included in the Plan solely as a mechanism to allow the Participant to include such amount in income and take a deduction on his or her income tax return and to describe the amount of the Employer's Health Savings Account contribution.

APPENDIX D

LIST OF PARTICIPATING EMPLOYERS

The following entities are Participating Employers under the Plan:

- Bituminous Materials and Supply L.P
- Heritage Aggregates LLC
- Real Estate Recovery Capital LLC