

VANGUARD TRUCK HOLDINGS, LLC CAFETERIA PLAN

PLAN DOCUMENT

08/01/2023

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ARTICLE 1 INTRODUCTION

Section 1.01 **PLAN**

The Plan Sponsor has established the Vanguard Truck Holdings, LLC Cafeteria Plan (the "Plan"), 501, effective as of 08/01/2023.

The Plan is intended to qualify as a cafeteria plan within the meaning of Code section 125. The Plan provides for the payment and reimbursement of certain benefits offered under the Plan.

Section 1.02 **APPLICATION OF PLAN**

Except as otherwise specifically provided herein, the provisions of this Plan shall apply to those individuals who are Eligible Employees of the Employer on or after the Effective Date. Except as otherwise specifically provided for herein, the rights and benefits, if any, of former Eligible Employees of the Employer whose employment terminated prior to the Effective Date, shall be determined under the provisions of the Plan as in effect from time to time prior to that date.

ARTICLE 2 DEFINITIONS

Account means

the bookkeeping balance of an account established for each Participant as of the applicable date. "Account" or "Accounts" shall include any account(s) or subaccount(s) as the Plan Administrator, in its discretion, deems appropriate.

Affiliate means

the Plan Sponsor or any other employer required to be aggregated with the Plan Sponsor under Code sections 414(b), (c), (m) or (o); provided, however, that "Affiliate" shall not include any entity or unincorporated trade or business prior to the date on which such entity, trade or business satisfies the affiliation or control tests described above.

Benefits means

the benefit options available to Eligible Employees under the Plan.

COBRA means

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

Code means

the Internal Revenue Code of 1986, as amended from time to time.

Compensation means

the cash wages or salary paid to a Participant.

Contract means

an insurance policy, contract or self-funded arrangement under which a Participant is eligible to receive benefits regardless of whether such policy, contract or arrangement is related to any benefit offered hereunder. "Contract" shall not include any product which is advertised, marketed, or offered as long-term care insurance. "Contract" shall not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an exchange established under section 1311 of such Act unless the Employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the Employee the opportunity to enroll through such exchange in a qualified health plan in a group market.

Dependent means

an individual who qualifies as a dependent of a Participant under Code section 152 (as modified by Code section 105(b)). For purposes of the Premium Conversion Account, "Dependent" does not include any individual who is not a dependent under the underlying Contract. A child who is determined to be a Participant's alternate recipient under a qualified medical child support order under ERISA section 609 shall be considered a Dependent under this Plan, as applicable.

Dependent Care Assistance Plan Account or **DCAP Account** means

the Account established with respect to the Participant's election to have dependent care expenses reimbursed by the Plan in accordance with Article 8.

Effective Date means

08/01/2023, provided that when a provision of the Plan states another effective date, such stated specific effective date shall apply as to that provision.

Eligible Employee means

an Employee described in Section 3.01 of the Plan. If an individual is subsequently reclassified as, or determined to be, an Employee by a court, the Internal Revenue Service or any other governmental agency or authority, or if the Employer is required to reclassify such individual an Employee as a result of such reclassification determination (including any reclassification by the Employer in settlement of any claim or action relating to such individual's employment status), such individual shall not become an Eligible Employee by reason of such reclassification or determination. An individual who becomes employed by an Employer in a transaction between the Employer and another entity that is a stock or asset acquisition, merger, or other similar transaction involving a change in the employer of the employees of the other entity shall not become eligible to participate in the Plan until the Employer or Plan Sponsor specifically authorizes such participation.

Employee means

any individual who is a common-law employee of an Employer, a leased employee as described in Code section 414(n), or full-time life insurance salesman as defined in Code section 7701(a)(20). The term "Employee" shall not include: (i) a self-employed individual (including a partner) as defined in Code section 401(c), or (ii) any person who owns (or is considered as owning within the meaning of Code section 318) more than 2 percent of the outstanding stock or combined voting power of an S corporation.

Employer means

the Plan Sponsor and any other entity that has adopted the Plan with the approval of the Plan Sponsor.

ERISA means

the Employee Retirement Income Security Act of 1974, as amended from time to time.

General Purpose Health Flexible Spending Account or General Purpose Health FSA means

the Account established with respect to the Participant's election to have medical expenses reimbursed by the Plan.

Health Flexible Spending Account or Health FSA means

the General Purpose Health FSA and/or HSA-Compatible Health FSA established with respect to the Participant's election to have medical expenses reimbursed by the Plan.

Health Savings Account or HSA means

a health savings account established in accordance with Article 9.

Highly Compensated Employee means

an Employee described in Code section 414(q).

Highly Compensated Individual means

an individual within the meaning of Code section 105(h)(5).

HIPAA means

the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

HRA means

a health reimbursement arrangement subject to Code section 105.

HSA-Compatible Health Flexible Spending Account or HSA-Compatible Health FSA means

a Limited Purpose Health Flexible Spending Account and/or a Post-Deductible Health Flexible Spending Account.

Key Employee means

an Employee described in Code section 416(i).

Leased Employee means

an Employee described in Code section 414(n)(2).

Limited Purpose Health Flexible Spending Account or Limited Purpose Health FSA means

the Account established with respect to the Participant's election to have medical expenses reimbursed by the Plan in accordance with Article 7.

Participant means

an Eligible Employee who participates in the Plan in accordance with Articles 3 and 4.

Plan means

the Vanguard Truck Holdings, LLC Cafeteria Plan.

Plan Administrator means

the person(s) designated pursuant to Section 11.01.

Plan Sponsor means

Vanguard Truck Holdings, LLC, organized under the state laws of Georgia.

Plan Year means

the 12-consecutive month period ending on 07/31.

Premium Conversion Account means

the Account established with respect to the Participant's election to have premiums reimbursed by the Plan.

Qualified Plan means

the retirement plan sponsored by an Employer and identified in the plan.

Salary Reduction Agreement means

the agreement pursuant to which an Eligible Employee elects to reduce his or her Compensation and instead receive a Benefit provided under the Plan.

Termination and Termination of Employment means

any absence from service that ends the employment of an Employee with the Employer.

ARTICLE 3 ELIGIBILITY

Section 3.01

ELIGIBLE EMPLOYEES

An Eligible Employee is any Employee coincident with or next following the first day of the calendar month following the date the Employee has attained at least 18 years of age and the Employee has completed at least 30 days of service.

An Eligible Employee is any employee who is not an excluded employee. An excluded employee is any employee who is a Union Employee, Leased Employee, Nonresident Alien and part-time employee who is expected to work fewer than 30 hours per week.

An Eligible Employee may elect to participate in the Plan in accordance with Article 4. Eligible Employees who were eligible to participate in the Plan immediately prior to the Effective Date shall be eligible to participate in the Plan on the Effective Date. Notwithstanding the foregoing, an Eligible Employee shall be eligible to make elections only for the Accounts as set forth herein.

Section 3.02

INELIGIBLE EMPLOYEES

The following Employees are not Eligible Employees and may not participate in any Benefit under the Plan: self-employed individuals (including partners), or persons who individually own (or are deemed to own) more than 2 percent of the outstanding stock of an Employer if it is an S corporation, or persons who are covered by a collective bargaining agreement that does not provide for participation in this Plan, leased employee, non-resident aliens who received no U.S. source earned income or part-time employee who is expected to work fewer than 30 hours per week. An Eligible Employee may be further modified by the provisions governing the applicable Benefit below.

Section 3.03

LEAVE OF ABSENCE

(a) *FMLA Leave of Absence.*

- (1) *Health Benefits.* If the Employer is or becomes subject to FMLA and a Participant takes a leave of absence under FMLA, the Participant shall be entitled to continue to participate in those Benefits under the Plan that provides health care. If a Participant takes an unpaid leave of absence under FMLA, the Participant may elect, with respect to the Benefits that provide health care under the Plan, to continue coverage but discontinue payment of his or her contribution for the period of the FMLA leave of absence. If the Participant's contributions are suspended during the leave of absence, the Employer may recover the Participant's suspended contributions when the Participant returns to work from the FMLA leave of absence. Participants who choose to continue coverage for health benefits under a FMLA leave of absence may elect to: pre-pay on a pre-tax (to the extent permissible under Code section 125) or after-tax basis the contributions due for the FMLA leave of absence period prior to commencement of the FMLA leave of absence period; pay on an after-tax basis the same schedule as payments would have been made if the Participant were not on a leave of absence or if contributions were being made under COBRA and to the extent agreed in advance repay amounts advanced by the Employer to the Plan on behalf of the Participant upon return from the FMLA leave of absence.
- (2) *Non-Health Benefits.* A Participant shall be entitled to continue to participate in Benefits under the Plan that do not provide health care in accordance with the Employer's established policy for providing such Benefits when an Employee is on non-FMLA leave. Participant contributions for Benefits during a leave of absence under FMLA shall be determined by the Plan Administrator in accordance with Code section 125.

- (b) *Non-FMLA Leave of Absence.* If a Participant takes an unpaid leave of absence other than under FMLA, the Participant shall be entitled to continue to participate in Benefits under the Plan in accordance with the Employer's established policy for providing such Benefits when an Employee is on non-FMLA leave.
- (c) *Applicable State Law.* The Plan Administrator shall permit a Participant to continue Benefits under the Plan as required under any applicable state law to the extent that such law is not pre-empted by federal law.
- (d) *Paid Leave of Absence.* A Participant shall not be entitled to revoke participation in any Benefits during a paid leave of absence except in accordance with Article 4.
- (e) *USERRA.* If a Participant is on a leave of absence in the uniformed services under the Uniformed Services Employment and Reemployment Rights Act (USERRA), the Participant shall be entitled to elect to continue participation in Premium Conversion Account, General Purpose Health Flexible Spending Account and HSA-Compatible Health Flexible Spending Account for the lesser of (i) 24 months, beginning on the date the Participant's absence began and (ii) the date the Participant fails to apply for or return to employment with the Employer, as determined under USERRA.

Section 3.04 **TERMINATION OF PARTICIPATION**

If a Participant remains an Employee but is no longer an Eligible Employee (e.g., due to a change in job classification), his or her participation in the Plan shall terminate on the last day of the month in which the Participant ceases to be an Eligible Employee.

Should such Employee again qualify as an Eligible Employee, he or she shall be eligible to participate in the Plan as of the first day of the subsequent Plan Year, unless earlier participation is required by applicable law or permitted in accordance with Section 4.03.

Section 3.05 **TERMINATION OF EMPLOYMENT**

If a Participant has a Termination of Employment, his or her participation in the Plan shall be governed in accordance with the terms of the applicable Benefit as provided herein.

Section 3.06 **REEMPLOYMENT**

- (a) The Plan Administrator shall automatically reinstate Benefit elections for Eligible Employees who are rehired by an Employer within 30 days of a Termination.
- (b) If an Employee has a Termination of Employment and is subsequently reemployed by the Employer as an Eligible Employee more than 30 days following the date of Termination, the Plan Administrator may allow the Eligible Employee to elect to reinstate the Benefit election in effect at the time of Termination or to make a new election under the Plan.
- (c) *Ineligible Employees.* An Employee who has a Termination of Employment and who is subsequently reemployed by the Employer but is not an Eligible Employee shall be eligible to participate on the date the individual becomes an Eligible Employee and, at that time, may elect to participate in the Plan in accordance with Article 4.

ARTICLE 4 BENEFITS AND PARTICIPATION

Section 4.01 **BENEFIT OPTIONS**

Each Participant may elect to participate in the following Benefits, pursuant to the applicable Article herein:

- (a) Premium Conversion Account
- (b) General Purpose Health Flexible Spending Account
- (c) HSA-Compatible Health Flexible Spending Account
- (d) Dependent Care Assistance Plan Account
- (e) Health Savings Account

Section 4.02 **ELECTION TO PARTICIPATE**

- (a) *Elections to Participate.* The Plan Administrator shall prescribe such forms and may require such data from an Eligible Employee as are reasonably required and permitted under applicable law to enroll the Eligible Employee in the Plan or to effectuate any elections made pursuant to this Article 4. The Plan Administrator may adopt procedures governing the elections described in this Article 4, including, without limitation, a minimum annual and per pay period contribution amount, a maximum contribution per pay period amount consistent with applicable annual limits, and the ability of a Participant to make after-tax contributions to the Plan.

ARTICLE 4 BENEFITS AND PARTICIPATION

- (b) *New Employees.* An Eligible Employee may elect to participate in the Benefits under the Plan during the period established by the Plan Administrator, which shall be no longer than 30 days after the date the Eligible Employee becomes an Employee. The election will be effective as of the Employee's hire date; provided, however, that amounts used to pay for such election must be made from Compensation not yet currently available on the date of the election.
- (c) *New Eligible Employees.* An Employee who becomes an Eligible Employee (for example, after satisfying the Plan's age and/or service requirements, if any) may elect to participate in the Benefits under the Plan during the period established by the Plan Administrator, which shall be no longer than 31 days after the date the Employee becomes an Eligible Employee. The election will be effective on a prospective basis.
- (d) *Continuing Eligible Employees.* An Eligible Employee may elect to enroll in the Plan or to modify or revoke his or her election during the period established by the Plan Administrator that precedes the Plan Year for which the election will be effective, except as provided in Article 9.
- (e) *Failure to Elect.* If an Eligible Employee does not make an election in accordance with the required enrollment procedures with respect to any or all Benefits under the Plan, the Eligible Employee will be deemed to have elected not to participate in such Benefit for the applicable Plan Year, except as otherwise provided herein.

Section 4.03 MID-YEAR ELECTION CHANGES

An Eligible Employee's election to participate in a Benefit hereunder is irrevocable during the Plan Year and may not be changed or revoked for any reason, except that an Eligible Employee may change his or her election during the Plan Year no later than the end of the 31-day period beginning on the date of a Change in Status (as defined below). The election change must be on account of and correspond with a Change in Status that affects eligibility for coverage under the Plan.

A Change in Status means the following:

- (a) *Legal Marital Status.* Events that change an Eligible Employee's legal marital status, including marriage, death of spouse, divorce, legal separation, and annulment.
- (b) *Number of Dependents.* Events that change an Eligible Employee's number of Dependents, including birth, death, adoption, and placement for adoption.
- (c) *Employment Status.* Any of the following events that change the employment status of the Eligible Employee, the Eligible Employee's spouse, or the Eligible Employee's Dependent: a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, and a change in worksite. In addition, if the eligibility conditions of the Plan or other employee benefit plan of the Employer of the Eligible Employee or the Eligible Employee's Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the applicable plan, then that change constitutes a change in employment under this paragraph (c).
- (d) *Dependent satisfies or ceases to satisfy eligibility requirements.* Events that cause an Eligible Employee's Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.
- (e) *Residence.* A change in the place of residence of the Eligible Employee or the Eligible Employee's spouse or Dependent.
- (f) *COBRA.* If the Eligible Employee or the Eligible Employee's spouse or Dependent becomes eligible for continuation coverage under an Employer's group health plan as provided in Code section 4980B or any similar state law, the Eligible Employee may elect to increase contributions to his or her Premium Conversion Account under the Plan in order to pay for the continuation coverage.
- (g) *Court Order.* A judgment, decree, or other order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in ERISA section 609) that requires accident or health coverage for an Eligible Employee's child or for a foster child who is a Dependent of the employee. The Eligible Employee may change his or her election to provide coverage for the child if the order requires coverage for the child under the Plan and may cancel coverage under the Plan for the child if the order requires the Eligible Employee's spouse, former spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided.

- (h) *Entitlement to Medicare or Medicaid.* If an Eligible Employee or an Eligible Employee's spouse or Dependent who is enrolled in an Employer's accident or health plan becomes enrolled under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Eligible Employee may make a prospective election change to cancel or reduce coverage of that Employee, spouse, or Dependent under the Employer-sponsored accident or health plan. In addition, if an Eligible Employee or an Eligible Employee's spouse or Dependent who has been enrolled in such coverage under Medicare or Medicaid loses eligibility for such coverage, the Eligible Employee may make a prospective election to commence or increase his or her coverage or the coverage of his or her spouse or Dependent, as applicable, under the Employer-sponsored accident or health plan.

- (i) *Significant Cost or Coverage Changes.*
 - (1) *Automatic Changes.* If the cost of an Employer-sponsored Contract premium increases (or decreases) during a period of coverage and, under the terms of the Contract, Eligible Employees are required to make a corresponding change in their payments, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in affected Eligible Employees' elective contributions for the Plan.

 - (2) *Significant Cost Changes.* If the cost charged to an Eligible Employee for a Contract benefit package option significantly increases or significantly decreases during a period of coverage, the Plan may permit the Eligible Employee to make a corresponding change in election under the Plan. Changes that may be made include commencing participation in the Plan for the option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under another benefit package option providing similar coverage or dropping coverage if no other benefit package option providing similar coverage is available. For example, if the cost of an indemnity option under an accident or health plan significantly increases during a period of coverage, Eligible Employees who are covered by the indemnity option may make a corresponding prospective increase in their payments or may instead elect to revoke their election for the indemnity option and, in lieu thereof, elect coverage under another benefit package option including an HMO option (or drop coverage under the accident or health plan if no other benefit package option is offered).

A cost increase or decrease refers to an increase or decrease in the amount of the elective contributions under the Plan, whether that increase or decrease results from an action taken by the Eligible Employee (such as switching between full-time and part-time status) or from an action taken by an Employer (such as reducing the amount of Employer contributions for a class of Eligible Employees). This paragraph (i) applies in the case of the Dependent Care Assistance Plan Account only if the cost change is imposed by a Dependent care provider who is not a relative of the Eligible Employee as described in Code section 152(a)(1) through (8), incorporating the rules of Code section 152(b)(1) and (2). This paragraph (i) does not apply to Health FSAs.

- (j) *Significant Curtailment Without Loss of Coverage.* If an Eligible Employee or an Eligible Employee's spouse and/or Dependent has a significant curtailment of coverage under a Contract during a period of coverage that is not a loss of coverage as described in paragraph (l) of this section (for example, there is a significant increase in the deductible, the copay, or the out-of-pocket cost sharing limit under the Contract), the Eligible Employee may revoke his or her election for that coverage and, in lieu thereof, elect to receive on a prospective basis coverage under another benefit package option providing similar coverage. This paragraph (j) does not apply to Health FSAs.

- (k) *Significant Curtailment With Loss of Coverage.* If an Eligible Employee (or an Eligible Employee's spouse or Dependent) has a significant curtailment that is a loss of coverage, the Eligible Employee may revoke his or her election under the Plan and, in lieu thereof, elect either to receive on a prospective basis coverage under another benefit package option providing similar coverage or to drop coverage if no similar benefit package option is available. For purposes of this paragraph (k), a loss of coverage means:
 - (1) a complete loss of coverage under the benefit package option or other coverage option (including the elimination of a benefits package option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation);
 - (2) a substantial decrease in the medical care providers available under the Contract (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO);
 - (3) a reduction in the benefits for a specific type of medical condition or treatment with respect to which the Eligible Employee or the Eligible Employee's spouse or Dependent is currently in a course of treatment; or
 - (4) any other similar fundamental loss of coverage as determined by the Plan Administrator's in its sole discretion.

This paragraph (k) does not apply to Health FSAs.

ARTICLE 4 BENEFITS AND PARTICIPATION

- (l) *Addition or Improvement of a Benefit Package Option.* If the Plan or a Contract adds a new benefit package option or other coverage option, or if coverage under an existing benefit package option or other coverage option is significantly improved during a period of coverage, an Eligible Employee may revoke his or her election under the Plan and, in lieu thereof, to make an election on a prospective basis for coverage under the new or improved benefit package option. This paragraph (l) does not apply to Health FSAs.
- (m) *Change in Coverage Under Another Employer Plan.* An Eligible Employee may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including another plan of the Employer or of another employer) if-
 - (1) The other cafeteria plan or qualified benefits plan permits participants to make an election change that would be permitted under paragraphs (a) through (n) of this section (disregarding this paragraph (m)(1)); or
 - (2) This Plan permits Eligible Employees to make an election for a Plan Year that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.

This paragraph (m) does not apply to Health FSAs.

- (n) *FMLA.* If a Participant contributes to the cost of such Benefit, he or she may revoke coverage or continue coverage but discontinue payment of his or her share of the cost of a Benefit that provides group health plan coverage (including a Health FSA) during the period of a leave of absence under FMLA. An Eligible Employee who revokes coverage shall be entitled to reinstate coverage upon returning from a leave of absence under FMLA.
- (o) *Loss of Coverage Under Other Group Health Coverage.* An Eligible Employee may make an election on a prospective basis to add coverage under the Plan for the Eligible Employee and/or the Eligible Employee's spouse and/or Dependent if the Eligible Employee and/or the Eligible Employee's spouse and/or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including a State's children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in section 7701(a)(40)), the Indian Health Service, or a tribal organization; a State health benefits risk pool; or a Foreign government group health plan. This paragraph (o) does not apply to Health FSAs.
- (p) *Revocation due to Reduction in Hours of Service.* A Participant may prospectively elect to cancel contribution for and payment of the Employee-paid portion of the Employer-sponsored group health plan Contract premiums if (1) the Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the Employer-sponsored group health plan and (2) the revocation of the election of coverage under the Employer-sponsored group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.
- (q) *Enrollment in a Qualified Health Plan.* A Participant may prospectively elect to cancel contribution for and payment of the employee-paid portion of the Employer-sponsored group health plan Contract premiums if (1) the Participant is eligible for a special enrollment period to enroll in a "qualified health plan" through a competitive marketplace established under Section 1311 of the Patient Protection and Affordable Care Act ("Marketplace") or the Employee seeks to enroll in a qualified health plan through a Marketplace during the Marketplace's annual open enrollment period.

The Plan Administrator reserves the right to determine whether an Eligible Employee has experienced a Change in Status and whether the Eligible Employee's requested election is consistent with such Change in Status.

ARTICLE 5 PREMIUM CONVERSION ACCOUNT

An Eligible Employee may elect to have a portion of his or her Compensation applied by the Employer toward the Premium Conversion Account. The Account established under this Article 5 is intended to qualify under Code sections 79 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

Section 5.01 **ELIGIBLE EMPLOYEES**

All Employees are eligible to participate in the Premium Conversion Account, except as otherwise specified in Article 3.

Section 5.02 **ENROLLMENT**

- (a) *Enrollment.* An Eligible Employee may enroll in the Premium Conversion Account in accordance with Article 4.
- (b) *Contributions.* A Participant's Premium Conversion Account will be credited with amounts withheld from the Participant's Compensation. The amount of a Participant's contribution to the Premium Conversion Account shall be equal to the amount of the Participant's portion of the premium on the applicable Contract. If the amount of the Participant's portion of the applicable premium on the Contract increases or decreases, the Participant's contribution to the Premium Conversion Account will automatically be adjusted to reflect the increase or decrease. Amounts in a Premium Conversion Account may be used toward the following benefits:
 - (1) Health coverage under the Employer's group health plan
 - (2) Dental coverage under the Employer's group dental plan
 - (3) Vision coverage under the Employer's group vision plan
 - (4) Supplemental Benefits
- (c) *Failure to Elect.* An Eligible Employee who affirmatively elected not to participate in the Premium Conversion Account for the Plan Year with respect to Employer-sponsored Contracts will not be enrolled in the Premium Conversion Account for any Plan Year until he or she affirmatively elects to participate in the Premium Conversion Account with respect to Employer-sponsored Contracts in accordance with Article 4.

Section 5.03 **ELIGIBLE EXPENSES**

A Participant's Premium Conversion Account will be debited for amounts applied to the Employee-paid portion of the applicable Contract premiums. The Plan Administrator will not direct the Employer to pay any premium on a Contract to the extent such payment exceeds the balance of a Participant's Premium Conversion Account.

Section 5.04 **TERMINATION OF EMPLOYMENT**

Upon a Participant's Termination of Employment, the Participant's contributions to the Premium Conversion Account will cease. Coverage under the applicable Contract may continue in accordance with the terms of the Contract for the remainder of the period of coverage with respect to which the required Contract premium has been paid.

ARTICLE 6 GENERAL PURPOSE HEALTH FLEXIBLE SPENDING ACCOUNT

Section 6.01 **IN GENERAL**

An Eligible Employee may elect to participate in a General Purpose Health Flexible Spending Account in accordance with this Article 6. The General Purpose Health FSA established under this Article 6 is intended to qualify as a health flexible spending arrangement under Code sections 105 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

Section 6.02 **ELIGIBLE EMPLOYEE**

The Employees identified in Article 3 are eligible to participate in the General Purpose Health Flexible Spending Account. An Employee who is not eligible to participate in an Employer-sponsored group health plan is not eligible to participate in the General Purpose Health FSA. An Eligible Employee who has elected to participate in the HSA Benefit and/or the HSA-Compatible Health FSA Benefit is not eligible to participate in the General Purpose Health FSA Benefit under this Article 6.

Section 6.03 **ENROLLMENT**

- (a) *Enrollment.* An Eligible Employee may enroll in the General Purpose Health FSA and elect to have a portion of his or her Compensation contributed to a General Purpose Health FSA in accordance with Article 4. A General Purpose Health FSA election is irrevocable for the Plan Year except in the event of a Change in Status as provided in Section 4.03.
- (b) *Contributions.* A Participant's General Purpose Health FSA will be credited with amounts withheld from the Participant's Compensation.
- (c) *Failure to Elect.* An Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to a General Purpose Health FSA for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 6.04 **LIMITS**

- (a) The amount of an Eligible Employee's contribution to a General Purpose Health Flexible Spending Account shall not exceed the limitations set forth in Code section 125(i), as adjusted.

Section 6.05 **ELIGIBLE EXPENSES**

- (a) *Debits from the General Purpose Health FSA.* A Participant's General Purpose Health FSA will be debited for expenses described in this Section 6.05. The entire annual amount elected by the Eligible Employee on the Salary Reduction Agreement for the Plan Year for the General Purpose Health FSA, less any reimbursements already disbursed from the General Purpose Health FSA, shall be available to the Participant at any time during the Plan Year without regard to the balance in the General Purpose Health FSA, provided that the amounts elected in the Salary Reduction Agreement have been contributed to date as provided in the Salary Reduction Agreement.
- (b) *Eligible Expenses.* A Participant may be reimbursed from his or her General Purpose Health FSA for expenses that are: (i) incurred in the Plan Year, (ii) incurred by the Participant, the Participant's spouse and dependents, if any, (iii) incurred while he or she is a Participant in the Plan, and (iv) excludable under Code section 105(b); provided that such expenses are not covered, paid or reimbursed from any other source. For purposes of determining whether an expense is excludable under Code section 105(b), the following applies:
 - (1) *Michelle's Law.* "Dependents" shall also include students who have not attained the age of 24 for whom coverage is required under Code section 9813; provided, that treatment as a dependent due to a medically necessary leave of absence under Code section 9813 shall not extend beyond a period of one year.
 - (2) *Coverage of Adult Children.* Expenses for a child (as defined in Code section 152(f)(1)) of the Participant may be covered until the child's 26th birthday.

Section 6.06 **REIMBURSEMENT**

- (a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from a Participant's General Purpose Health FSA for eligible expenses incurred during the Plan Year.
- (b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement from his or her General Purpose Health FSA during the Plan Year and no later than 90 days after the end of the Plan Year. The claim must be made in the manner required by the Plan Administrator.
- (c) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall: (i) reimburse the Participant, or (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from the General Purpose Health FSA. The Plan Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. The Plan Administrator may provide that payments/reimbursements from the General Purpose FSA of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year shall be reimbursed without regard to the minimum payment amount.
- (d) *Coordination with HRA.* A Participant who is also eligible to participate in an HRA sponsored by the Employer shall not be entitled to payment/reimbursement under the General Purpose Health FSA for expenses that are reimbursable under both the General Purpose Health FSA and the HRA until the Participant has received his or her maximum reimbursement under the HRA. Notwithstanding the foregoing, a Participant shall be entitled to payment/reimbursement under the General Purpose Health FSA if, before the Plan Year begins, the plan document for the HRA specifies that coverage under the HRA is available only after expenses exceeding the applicable dollar amounts in the General Purpose Health FSA have been paid.
- (e) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of debit or stored value cards for payment of eligible General Purpose Health FSA expenses.

Section 6.07 **FORFEITURES**

- (a) *Forfeitures.* Any balance remaining in a Participant's General Purpose Health FSA at the end of any Plan Year subject to the carryover amount limit in subsection (b) below, shall be forfeited and shall be used to (1) pay administrative expenses, (2) offset losses to the Health FSA due to reimbursements exceeding contributions for the Plan Year, (3) reduce the required salary reduction amounts for the next Plan Year, (4) reduce the required employer contributions for the next Plan Year, (5) reallocate to participants on a uniform basis, and/or (6) any other use allowed under all applicable laws and regulations. If the General Purpose Health FSA is not subject to ERISA, the forfeited amount can be returned to the Employer.
- (b) *Carryovers.* Notwithstanding subsection (a), the Plan will carry over to the immediately following Plan Year up to \$610.00 of any amount remaining unused as of the end of the Plan Year in a Participant's General Purpose Health FSA. The amount remaining unused as of the end of the Plan Year is the balance in the General Purpose Health FSA after all eligible expenses have been reimbursed and the claims deadline for the Plan Year has passed. The carryover amount may be used to pay or reimburse eligible expenses incurred during the Plan Year to which it is carried over. Any unused amount remaining in the General Purpose Health FSA in excess of the carryover limit will be forfeited in accordance with subsection (a) above. The Plan Administrator may prescribe procedures for the carryover including, but not limited to, establishing a minimum amount for carryover and requiring a Participant to use the rollover in the following Plan Year, provided that any such procedure is non-discriminatory.

ARTICLE 6 GENERAL PURPOSE HEALTH FLEXIBLE SPENDING ACCOUNT

Section 6.08 CARRYOVER TO AN HSA-COMPATIBLE HEALTH FSA

If a Participant who has elected a General Purpose Health FSA for a given Plan Year establishes a Health Savings Account under the Plan or otherwise for the subsequent Plan Year, he or she may elect (or may be deemed by the Plan Administrator to have elected) as of the last day of the Plan Year (the "Conversion Date") to carryover the balance in his or her General Purpose Health FSA to an available HSA-Compatible Health FSA for the subsequent Plan Year to the extent selected in the Adoption Agreement. An HSA-Compatible Health FSA cannot be converted into a General Purpose Health FSA.

Section 6.09 TERMINATION OF EMPLOYMENT

Contributions to a Participant's General Purpose Health FSA shall cease upon Termination of Employment. Any balance remaining in a Participant's General Purpose Health FSA on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer, except as expressly provided herein. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within 90 days after termination.

Section 6.10 QUALIFIED RESERVIST DISTRIBUTIONS

- (a) A Participant may receive a distribution of the amount contributed to his or her General Purpose Health FSA as of the date of the Qualified Reservist Distribution request minus General Purpose Health FSA reimbursements received as of the date of the Qualified Reservist Distribution request. The distribution will only be made if: (i) such Participant was a member of a reserve component ordered or called to active duty for a period in excess of 179 days or for an indefinite period and (ii) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of such order or call. A Qualified Reservist Distribution may not be made based on an order or call to active duty of any individual other than the Participant, including the spouse of the Participant.
- (b) A Participant may submit General Purpose Health FSA claims for medical expenses incurred before the date a Qualified Reservist Distribution is requested. The Participant shall not have the right to submit claims for medical expenses incurred after the date such Qualified Reservist Distribution is requested. The Plan shall pay the Qualified Reservist Distribution to the Participant within a reasonable time, but not more than sixty days after the request for a Qualified Reservist Distribution has been made.
- (c) This Subsection shall be construed in accordance with IRS Notice 2008-82 and any superseding guidance.

Section 6.11 SEPARATE PLAN

Although described within this document, the General Purpose Health FSA is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 105. The General Purpose Health FSA is also a separate plan for purposes of ERISA, HIPAA, and COBRA.

ARTICLE 7 HSA-COMPATIBLE HEALTH FLEXIBLE SPENDING ACCOUNT

Section 7.01 IN GENERAL

An Eligible Employee may elect to have a portion of his or her Compensation contributed to an HSA-Compatible Health FSA. The HSA-Compatible Health FSA established here under is intended to qualify as a health flexible spending arrangement under Code sections 105 and 106(a) and shall be interpreted in a manner consistent with such Code sections.

Section 7.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 are eligible to participate in the HSA-Compatible Health FSA Benefit. An Employee who is not eligible to participate in an Employer-sponsored group health plan is not eligible to participate in the HSA-Compatible Health FSA. A Participant who has elected to participate in the General Purpose Health FSA is not eligible to elect an HSA-Compatible Health FSA, except as otherwise provided in Section 7.08.

Section 7.03 ENROLLMENT

- (a) *Enrollment.* An Eligible Employee may enroll in an HSA-Compatible Health FSA in accordance with Article 4. An HSA-Compatible Health FSA election is irrevocable for the Plan Year except in the event of a Change in Status as provided in Section 4.03. An Eligible Employee's election to enroll in an HSA-Compatible Health FSA will not become effective until the Employee is enrolled in an Employer-sponsored group health plan.
- (b) *Contributions.* A Participant's HSA-Compatible Health FSA will be credited with amounts withheld from the Participant's Compensation.

ARTICLE 7 HSA-COMPATIBLE HEALTH FLEXIBLE SPENDING ACCOUNT

- (c) *Failure to Elect.* An Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to an HSA-Compatible Health FSA for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 7.04 LIMITS

The amount of an Eligible Employee's contribution to an HSA-Compatible Health FSA shall not exceed the limitations set forth in Code section 125(i), as adjusted.

Section 7.05 ELIGIBLE EXPENSES

- (a) *Debits from the HSA-Compatible Health FSA.* A Participant's HSA-Compatible Health FSA will be debited for expenses described in this Section. The entire annual amount elected by the Eligible Employee on the Salary Reduction Agreement for the Plan Year for the HSA-Compatible Health FSA, less any reimbursements already disbursed for the Plan, shall be available to the Participant at any time during the Plan Year without regard to the balance in the HSA-Compatible Health FSA, provided that the amounts elected in the Salary Reduction Agreement have been contributed to date as provided in the Salary Reduction Agreement.
- (b) *HSA-Compatible Health FSA.* A Participant may be reimbursed from his or her HSA-Compatible Health FSA for expenses that are: (i) incurred in the Plan, (ii) incurred while the Participant participates in the Plan, (iii) excludable under Code section 105(b), (iv) incurred for dental or vision care or for preventive care (as defined under Code section 223(c)(2)(C)), and (v) incurred for telehealth services as defined in Code section 223(c)(2)(E); provided that such expenses that are not covered, paid or reimbursed from any other source.
- (c) For purposes of determining whether an expense is excludable under Code section 105(b), the following applies
- (1) *Michelle's Law.* "Dependents" shall also include students who have not attained the age of 24 for whom coverage is required under Code section 9813; provided, that treatment as a Dependent due to a medically necessary leave of absence under Code section 9813 shall not extend beyond a period of one year.
- (2) *Coverage of Adult Children.* Expenses for a child (as defined in Code section 152(f)(1)) of the Participant may be covered until the child's 26th birthday.

Section 7.06 REIMBURSEMENT

- (a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from a Participant's HSA-Compatible Health FSA for eligible expenses incurred during the Plan Year.
- (b) *Period for Submitting Claims.* The claim must be made in the manner required by the Plan Administrator.
- (c) *Substantiation of Claims.* A Participant's claims for reimbursement from a Limited-Purpose Health FSA must include information from an independent third-party that the medical expenses to be reimbursed are for vision care, dental care or preventive care.
- (d) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall: (i) reimburse the Participant, or (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from the HSA-Compatible Health FSA. The Plan Administrator shall establish a schedule, not less frequently than monthly, for the payment of claims. The Plan Administrator may provide that payments/reimbursements from the HSA-Compatible Health FSA of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year shall be reimbursed without regard to the minimum payment amount.
- (e) *Coordination with HRA.* A Participant who is also eligible to participate in an HRA sponsored by the Employer shall not be entitled to payment/reimbursement under the HSA-Compatible Health FSA for expenses that are reimbursable under both the HSA-Compatible Health FSA and the HRA until the Participant has received his or her maximum reimbursement under the HRA. Notwithstanding the foregoing, a Participant shall be entitled to payment/reimbursement under the HSA-Compatible Health FSA if, before the Plan Year begins, the plan document for the HRA specifies that coverage under the HRA is available only after expenses exceeding the applicable dollar amounts in the HSA-Compatible Health FSA have been paid.
- (f) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of debit or stored value cards for payment of eligible HSA-Compatible Health FSA expenses.

Section 7.07 **FORFEITURES**

- (a) *Forfeitures.* Any balance remaining in a Participant's HSA-Compatible Health FSA at the end of any Plan Year that is above the carryover amount limit in subsection (b) below shall be forfeited and shall be used to (1) pay administrative expenses, (2) offset losses to the Health FSA due to reimbursements exceeding contributions for the Plan Year, (3) reduce the required salary reduction amounts for the next Plan Year, (4) reduce the required employer contributions for the next Plan Year, (5) reallocate to participants on a uniform basis, and/or (6) any other use allowed under all applicable laws and regulations. If the HSA-Compatible Health FSA is not subject to ERISA, the forfeited amount can be returned to the Employer.
- (b) *Carryovers.* Notwithstanding subsection (a), the Plan will carry over to the immediately following Plan Year up to \$610.00 of any amount remaining unused as of the end of the Plan Year in a Participant's HSA-Compatible Health FSA. The amount remaining unused as of the end of the Plan Year is the balance in the HSA-Compatible Health FSA after all eligible expenses have been reimbursed and the claims deadline for the Plan Year has passed. The carryover amount may be used to pay or reimburse eligible expenses incurred during the entire Plan Year to which it is carried over. Any unused amount remaining in the HSA-Compatible Health FSA in excess of the carryover limit will be forfeited in accordance with subsection (a) above. The Plan Administrator may prescribe procedures for the carryover including, but not limited to, establishing a minimum amount for carryover and requiring a Participant to use the carryover in the following Plan Year, provided that any such procedure is non-discriminatory.

Section 7.08 **TERMINATION OF EMPLOYMENT**

Contributions to a Participant's HSA-Compatible Health FSA shall cease upon Termination of Employment. Any balance remaining in a Participant's HSA-Compatible Health FSA on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer, except as expressly provided herein. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within 90 days after termination.

Section 7.09 **QUALIFIED RESERVIST DISTRIBUTIONS**

- (a) A Participant may receive a distribution of the amount contributed to his or her HSA-Compatible Health FSA as of the date of the Qualified Reservist Distribution request minus HSA-Compatible Health FSA reimbursements received as of the date of the Qualified Reservist Distribution request. The distribution will only be made if: (i) such Participant was a member of a reserve component ordered or called to active duty for a period in excess of 179 days or for an indefinite period and (ii) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under the Plan for the Plan Year which includes the date of such order or call. A Qualified Reservist Distribution may not be made based on an order or call to active duty of any individual other than the Participant, including the spouse of the Participant.
- (b) A Participant may submit HSA-Compatible Health FSA claims for medical expenses incurred before the date a Qualified Reservist Distribution is requested. The Participant shall not have the right to submit claims for medical expenses incurred after the date such Qualified Reservist Distribution is requested. The Plan shall pay the Qualified Reservist Distribution to the Participant within a reasonable time, but not more than sixty days after the request for a Qualified Reservist Distribution has been made.
- (c) This Subsection shall be construed in accordance with IRS Notice 2008-82 and any superseding guidance.

Section 7.10 **SEPARATE PLAN**

Although described within this document, the HSA-Compatible Health FSA is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 105. The HSA-Compatible Health FSA is also a separate plan for purposes of ERISA, HIPAA, and COBRA.

ARTICLE 8 DEPENDENT CARE ASSISTANCE PLAN ACCOUNT

Section 8.01 **IN GENERAL**

An Eligible Employee may elect to have a portion of his or her Compensation contributed to a Dependent Care Assistance Plan Account. The DCAP Account established hereunder is intended to qualify as a dependent care assistance program under Code section 129 and shall be interpreted in a manner consistent with such Code section.

Section 8.02 **ELIGIBLE EMPLOYEES**

The Employees identified in Article 3 are eligible to participate in the Dependent Care Assistance Plan Account.

Section 8.03 **ENROLLMENT**

- (a) *Enrollment.* An Eligible Employee may enroll in the DCAP Account in accordance with Article 4.

ARTICLE 8 DEPENDENT CARE ASSISTANCE PLAN ACCOUNT

- (b) *Contributions.* A Participant's DCAP Account will be credited with amounts withheld from the Participant's Compensation.
- (c) *Failure to Elect.* An Eligible Employee who fails to submit a Salary Reduction Agreement in accordance with the procedures adopted by the Plan Administrator shall not have any portion of his or her Compensation contributed to a DCAP Account for the Plan Year, regardless of the election he or she had in effect for the prior Plan Year.

Section 8.04 LIMITS

The amount of all contributions to a Participant's DCAP Account shall not exceed the limitations set forth in Code section 129(a)(2), as adjusted.

Section 8.05 ELIGIBLE EXPENSES

- (a) *Debits from the DCAP Account.* A Participant's DCAP Account will be debited for expenses described in this Section. However, the Plan Administrator will not direct the Employer to reimburse such expenses to the extent the reimbursement exceeds the balance of the Participant's DCAP Account.
- (b) *Eligible Expenses.* Participant may be reimbursed from his or her DCAP Account for Dependent Care Expenses that are: (i) incurred in the Plan Year, (ii) are incurred while the Participant participates in the Plan, and (iii) qualify as eligible Dependent Care Expenses (as defined below), provided that such expenses that are not covered, paid or reimbursed from any other source and the Participant does not claim a tax benefit for the such expenses.
 - (1) "Dependent Care Expenses" are expenses incurred for the care of a Qualifying Individual, as defined in Code section 21(b)(1) and generally includes either: (i) a Dependent who is under age 13, or (ii) the Participant's spouse or Dependent who lives with the Participant and is physically or mentally incapable of caring for himself/herself. However, these expenses are Dependent Care Expenses only if they allow the Participant to be gainfully employed. Dependent Care Expenses include expenses for household services and expenses for the care of a Qualifying Individual. Such term shall not include any amount paid for services outside the Participant's household at a camp where the Qualifying Individual stays overnight. Expenses described in this subsection (2) that are incurred for services outside the Participant's household are not taken into account if they are incurred on behalf of the Participant's spouse or Dependent who is physically or mentally incapable of caring for himself/herself unless such individual lives at least eight hours per day in the Participant household. Expenses incurred at a dependent care center are taken into account only if such center complies with all applicable laws and regulations of a state or local government, the center provides care for more than six individuals, and the center receives a fee, payment, or grant for providing services for any of the individuals.

Section 8.06 REIMBURSEMENT

- (a) *Period for Reimbursement.* The Plan Administrator shall direct the reimbursement from a Participant's DCAP Account for eligible expenses incurred during the Plan Year. An individual who ceases to be a Participant in the Plan (due to Termination or any other reason) may spend down his or her unused DCAP Account expenses, and such individuals may be reimbursed for unused benefits through the end of the Plan Year in which the Termination of Participation occurs to the extent the claims do not exceed the balance of the DCAP Account.
- (b) *Period for Submitting Claims.* A Participant may submit a request for reimbursement from his or her DCAP Account during the Plan Year and no later than 90 days after the end of the Plan Year. The claim must be made in the manner required by the Plan Administrator.
- (c) *Payment of Claims.* To the extent that the Plan Administrator approves the claim, the Employer shall: (i) reimburse the Participant, or (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from DCAP Account. The Plan Administrator may provide that payments/reimbursements from the DCAP Account of less than a certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Plan Year shall be reimbursed without regard to the minimum payment amount.
- (d) *Debit Card.* Subject to IRS guidelines, the Plan Administrator may provide for the use of debit or stored value cards for payment of eligible DCAP Account expenses.

Any balance remaining in a Participant's DCAP Account at the end of the Plan Year shall be forfeited and shall remain the property of the Employer. Unused contributions to a DCAP Account may not be cashed-out or converted to any other taxable or nontaxable benefit.

Section 8.08 TERMINATION OF EMPLOYMENT

Contributions to a Participant's DCAP Account shall cease upon Termination of Employment. Any balance remaining in a Participant's DCAP Account on the date of his or her Termination of Employment shall be forfeited and shall remain the property of the Employer, except as expressly provided herein. However, no forfeiture shall occur until all payments and reimbursements hereunder have been made on claims submitted within 90 days after termination.

Section 8.09 SEPARATE PLAN

Although described within this document, the DCAP Account is a separate plan for purposes of administration and all reporting and nondiscrimination requirements imposed by Code section 129. The DCAP Account is also a separate plan for purposes of ERISA, HIPAA, and COBRA.

ARTICLE 9 HEALTH SAVINGS ACCOUNT

Section 9.01 IN GENERAL

An Eligible Employee may elect to have a portion of his or her Compensation contributed to a Health Savings Account. The Health Savings Account established hereunder is intended to qualify as a health savings account under Code section 223 and shall be interpreted in a manner consistent with such Code section.

Section 9.02 ELIGIBLE EMPLOYEES

The Employees identified in Article 3 who, as of the first day of the month, are enrolled in a high deductible health plan as defined in Code section 223(c)(2) are eligible to contribute to the Health Savings Account for the month. An Eligible Employee who has elected to participate in a General Purpose Health FSA (if applicable) is not eligible to participate in the HSA Benefit under this Article 9. A Participant who has elected a General Purpose Health FSA Benefit which has a Grace Period that is in effect on the last day of a Plan Year cannot elect the HSA Benefit under this Article 9 for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's General Purpose Health FSA is \$0 as of the last day of such Plan Year.

Section 9.03 ENROLLMENT

- (a) *Enrollment.* An Eligible Employee may enroll in the HSA in accordance with Article 4. An HSA election may be modified as determined by the Plan Administrator, but no less frequently than monthly; provided, however, that any modification of an election during the Plan Year shall apply on a prospective basis only. A participant who becomes ineligible to make HSA contributions may prospectively revoke his or her HSA contribution election.
- (b) *Contributions.* A Participant's HSA will be credited with amounts withheld from the Participant's Compensation. The Employer may make discretionary matching contributions to Participants' HSA.
- (c) *Failure to Elect.* An Employee who participated in the HSA for the prior Plan Year and who fails to submit a Salary Reduction Agreement for the next following Plan Year in accordance with the procedures adopted by the Plan Administrator shall have his or her election from the immediately prior Plan Year apply to the HSA for such subsequent Plan Year.

Section 9.04 LIMITS

The amount of contributions to a Participant's HSA shall not exceed the limitations set forth in Code section 223(b), as adjusted.

Section 9.05 ADMINISTRATION

The HSA Benefit is not an employer-sponsored employee benefit plan-it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the Employer does not establish or maintain the HSA. The Plan Administrator will maintain records to keep track of HSA contributions by the Employer and by the Participant, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

Section 9.06 TERMINATION OF EMPLOYMENT

Except as expressly provided herein, all contributions to a Participant's HSA will terminate upon a Termination of Employment. The Participant will continue to be eligible to receive distribution from his or her HSA in accordance with the terms of the documents governing the HSA.

ARTICLE 10 NONDISCRIMINATION

Section 10.01 NONDISCRIMINATION REQUIREMENTS

The following nondiscrimination requirements shall apply:

- (a) *Cafeteria Plan.* The Plan may not discriminate in favor of Highly Compensated Individuals as to benefits provided or eligibility to participate.
- (b) *Group Term Life.* The Plan may not discriminate in favor of Key Employees as to benefits provided or eligibility to participate with respect to any group term life insurance.

- (c) *Health Flexible Spending Account.* The Plan may not discriminate in favor of Highly Compensated Individuals as to benefits provided or eligibility to participate with respect to the Health FSA.
- (d) *Dependent Care Assistance Plan Accounts.* The Plan may not discriminate in favor of Highly Compensated Employees as to benefits provided or eligibility to participate with respect to DCAP Accounts.

Section 10.02 **ADJUSTMENTS**

If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify any election in order to assure compliance with such requirements or limitations. Any act taken by the Plan Administrator under this Section shall be carried out in a uniform and non-discriminatory manner.

ARTICLE 11 PLAN ADMINISTRATION

Section 11.01 **PLAN ADMINISTRATOR**

- (a) *Designation.* The Plan Administrator shall be the Plan Sponsor. If a Committee is designated as the Plan Administrator, the Committee shall consist of one or more individuals who may be Employees appointed by the Plan Sponsor. The Committee shall elect a chair and may adopt such rules and procedures as it deems desirable. The Committee may also take action with or without formal meetings and may authorize one or more individuals, who may or may not be members of the Committee, to execute documents on its behalf. The Plan Administrator shall also be the Plan "administrator" as such term is defined in section 3(16) of ERISA and the "named fiduciary" of the Plan (only to the extent that the Plan is subject to ERISA).
- (b) *Authority and Responsibility of the Plan Administrator.* The Plan Administration shall have total and complete discretionary power and authority:
 - (1) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;
 - (2) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits under the Plan;
 - (3) to determine the amount and manner of any allocations hereunder;
 - (4) to maintain and preserve records relating to the Plan;
 - (5) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;
 - (6) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;
 - (7) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;
 - (8) to determine all questions of the eligibility and of the status of rights of Participants;
 - (9) to adjust Accounts in order to correct errors or omissions;
 - (10) to determine the validity of any judicial order;
 - (11) to retain records on elections and waivers by Participants;
 - (12) to supply such information to any person as may be required; and
 - (13) to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.
- (c) *Procedures.* The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished to it. The Plan Administrator's decisions shall be binding and conclusive as to all parties.

- (d) *Allocation of Duties and Responsibilities.* The Plan Administrator may designate other persons to carry out any of his duties and responsibilities under the Plan.
- (e) *Compensation.* The Plan Administrator shall serve without compensation for its services.
- (f) *Expenses.* All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the Plan Sponsor.

Section 11.02 **INDEMNIFICATION**

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

ARTICLE 12 AMENDMENT AND TERMINATION

Section 12.01 **AMENDMENT**

The provisions of the Plan may be amended in writing at any time and from time to time by the Plan Sponsor or its delegate.

Section 12.02 **TERMINATION**

- (a) It is the intention of the Plan Sponsor that this Plan will continue indefinitely; however, the Plan Sponsor reserves the right to terminate the Plan at any time for any reason.
- (b) A participating Employer may terminate its participation in this Plan upon (i) written notice to the Plan Sponsor of its intent to terminate participation in the Plan, (ii) the closing of a merger in which the participating Employer is not the surviving entity and the surviving entity is not an affiliate of the Plan Sponsor, or (iii) the sale of all or substantially all of the participating Employer's assets to an entity that is not an affiliate of the Plan Sponsor.

ARTICLE 13 CLAIMS PROCEDURES

Section 13.01 **CLAIMS PROCEDURES**

- (a) *Non-Plan Claims.* Claims and reimbursement for benefits provided under any Contract shall be administered in accordance with the claims procedures for the applicable Contract, as set forth in the Contract's plan documents, summary plan description, and/or similar documentation. Claims and reimbursement for benefits provided under any Contract shall be administered in accordance with the claims procedures for the applicable Contract, as set forth in the Contract's plan documents, summary plan description, and/or similar documentation relating to the HSA shall be administered by the HSA trustee/custodian in accordance with the HSA trust or custodial document between the Participant and such trustee/custodian.
- (b) *Plan Claims.* A request for benefits is a "claim" subject to this Section only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that the inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information. Participants may designate an authorized representative if written notice of such designation is provided.
- (c) *Documentation.* A Participant or any other person requesting benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim shall include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim. All claims and notices shall be made in written form unless the Plan Administrator provides procedures for such claims and notices to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.
- (d) *Health Flexible Spending Account Claims.* This subsection shall apply for any claim for benefits under the Health Flexible Spending Account.
 - (1) *Timing of Notice of Denied Claim.* The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the

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

- (2) *Content of Notice of Denied Claim.* If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (A) the reason or reasons for such denial, (B) the pertinent Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA after following the Plan's claims procedures, and (E): (1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or (2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- (3) *Appeal of Denied Claim.* If a Claimant wishes to appeal the denial of a claim, he shall file an appeal with the Plan Administrator on or before the 180th day after he receives the Plan Administrator's notice that the claim has been wholly or partially denied. The Claimant shall lose the right to appeal if the appeal is not timely made. The appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Plan Administrator shall consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator shall:
 - (A) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
 - (B) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
 - (C) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
 - (D) Provide that the health care professional engaged for purposes of a consultation under Subsection (B) shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination.

- (4) *Denial of Appeal.* If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying (A) the reason or reasons for such denial, (B) the pertinent Plan provisions on which the denial is based, (C) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits, and (D) a statement describing the Claimant's right to bring an action under section 502(a) of ERISA after following the Plan's claims procedures. The determination rendered by the Plan Administrator shall be binding upon all parties.
- (5) *Exhaustion of Remedies; Limitations Period for Filing Suit.* Before a suit can be filed in federal court, claims must exhaust internal remedies. Unless otherwise provided under the Plan or required pursuant to applicable law, a suit for benefits under the Health Flexible Spending Account must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.
- (e) *Other Plan Account Claims.* This subsection shall apply for any claim for benefits under Accounts that is not a health flexible spending account.

ARTICLE 13 CLAIMS PROCEDURES

- (1) *Timing of Notice of Denied Claim.* The Plan Administrator shall notify the Claimant of any adverse benefit determination within a reasonable period of time, ordinarily within 90 days after receipt of the claim, unless the Plan Administrator determines additional time is required to make a determination.
- (2) *Content of Notice of Denied Claim.* If a claim is wholly or partially denied, the Plan Administrator shall provide the Claimant with a written notice identifying the reason or reasons for such denial and an explanation of the steps that the Claimant must take if he wishes to appeal the denial.
- (3) *Appeal of Denied Claim.* If a Claimant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied. The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. A written appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Claimant shall lose the right to appeal if the appeal is not timely made. The Plan Administrator shall rule on an appeal within a reasonable period of time, ordinarily within 60 days of receipt of the appeal, unless the Plan Administrator determines additional time is required to make a determination.
- (4) *Denial of Appeal.* If an appeal is wholly or partially denied, the Plan Administrator shall provide the Claimant with a notice identifying the reason or reasons for such denial. The determination rendered by the Plan Administrator shall be binding upon all parties.
- (5) *Exhaustion of Remedies; Limitations Period for Filing Suit.* Unless otherwise prohibited under the Plan or pursuant to applicable law, before a suit can be filed in court, Claimants must exhaust the Plan's claim procedures. Unless otherwise provided under the Plan or required pursuant to applicable law, a suit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Section 13.02 REFUNDS/INDEMNIFICATION

If the Plan Administrator determines that any Claimant has directly or indirectly received excess payments/reimbursements or has received payments/reimbursements that are taxable to the Claimant, the Plan Administrator shall notify the Claimant and the Claimant shall repay such excess amount (or at the option of the Plan Administrator, the Claimant shall repay the amount that should have been withheld or paid as payroll or withholding taxes) as soon as possible, but in no event later than 30 days after the date of notification. A Claimant shall indemnify and reimburse the Employer for any liability the Employer may incur for making such payments, including but not limited to failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If the Claimant fails to timely repay an excess amount and/or make sufficient indemnification, the Plan Administrator may: (a) to the extent permitted by applicable law, offset the Claimant's salary or wages, and/or (b) offset other benefits payable hereunder.

ARTICLE 14 MISCELLANEOUS

Section 14.01 NONALIENATION OF BENEFITS

No Participant or Beneficiary shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which he or she may expect to receive, contingently or otherwise, under the Plan.

Section 14.02 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan shall be construed as a contract of employment between the Employer and the Participant, or as a right of any Employee to continue in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its Employees, with or without cause.

Section 14.03 NO FUNDING REQUIRED

Except as otherwise required by law:

- (a) Any amount contributed by a Participant and/or the Employer to provide benefits hereunder shall remain part of the general assets of the Employer and all payments of benefits under the Plan shall be made solely out of the general assets of the Employer.
- (b) The Employer shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the Employer may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.
- (c) No person shall have any rights to, or interest in, any Benefit or account other than as expressly authorized in the Plan.

Section 14.04 **MEDICAL CHILD SUPPORT ORDERS**

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

To the extent the Plan is not subject to ERISA, any applicable law related to qualified medical child support orders or National Medical Support Notices shall apply and the Plan Administrator shall follow any required procedures under such law.

Section 14.05 **GOVERNING LAW**

- (a) The Plan shall be construed in accordance with and governed by the laws of Georgia, to the extent not preempted by Federal law.
- (b) The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

Section 14.06 **TAX EFFECT**

The Employer does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan.

Section 14.07 **SEVERABILITY OF PROVISIONS**

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

Section 14.08 **HEADINGS AND CAPTIONS**

The headings and captions herein are provided for reference and convenience only, shall not be considered part of the Plan, and shall not be employed in the construction of the Plan.

Section 14.09 **GENDER AND NUMBER**

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.

Section 14.10 **TRANSFERS**

Except as explicitly set forth herein, amounts may not be transferred between Accounts.

Section 14.11 **COBRA**

If the Plan or Benefit is subject to COBRA (Code section 4980B and other applicable state law) or the Plan Administrator determines that the Plan or Benefit is subject to COBRA, a Participant shall be entitled to continuation coverage as prescribed in Code section 4980B (and the regulations thereunder) or such applicable state statutes.

Section 14.12 **CONFLICTS**

In the event of a conflict between the terms of this Plan and the terms of a Contract, the terms of the Contract (or the benefit plan under which it is established) shall control in defining the terms and conditions of coverage including, but not limited to, the persons eligible for coverage, the dates of their eligibility, the conditions that must be satisfied to become covered, if any, the benefits Participants are entitled to receive and the circumstances under which coverage terminates.

Section 14.13 **DEATH**

If a Participant dies, his beneficiaries or his estate may submit claims for expenses or benefits for the portion of the Plan Year preceding the date of the Participant's death. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Plan Administrator may pay any amount due hereunder to the Participant's spouse, one or more of his or her Dependents or a representative of the Participant's estate. Such payment shall fully discharge the Plan Administrator and the Employer from further liability on account thereof.

ARTICLE 15 HIPAA PRIVACY AND SECURITY COMPLIANCE

This Article shall only apply in the event that the Health FSA under the Plan constitutes a group health plan as defined in section 2791(a)(2) of the Public Health Service Act or if the Plan Administrator determines that the Plan is subject to the HIPAA privacy and security rules. The Plan will comply with HIPAA as set forth below.

Section 15.01 DEFINITIONS

For purposes of this Article, the following terms have the following meanings:

- (a) Business Associate means any outside vendor who performs a function or activity on behalf the Plan which involves the creation, use or disclosure of PHI, and includes any subcontractor to whom a Business Associate delegates its obligations.
- (b) Group Health Benefits means the medical benefits, dental benefits, vision benefits and, if applicable, employee assistance program benefits offered under the Plan.
- (c) Individual means the Participant or the Participant's covered dependents enrolled in any of the Group Health Benefits under the Plan.
- (d) Notice of Privacy Practices means a notice explaining the uses and disclosures of PHI that may be made by the Plan, the covered Individuals' rights under the Plan with respect to PHI, and the Plan's legal duties with respect to PHI.
- (e) Plan Administration Functions means the administration functions performed by the Plan Sponsor on behalf of the Plan. Plan Administration Functions do not include functions performed by the Plan Sponsor in connection with any other benefit plan of the Plan Sponsor.
- (f) Protected Health Information ("PHI") means information about an Individual, including genetic information, (whether oral or recorded in any form or medium) that:
 - (1) is created or received by the Plan or the Plan Sponsor;
 - (2) relates to the past, present or future physical or mental health or condition of the Individual, the provision of health care to the Individual, or the past, present or future payment for the provision of health care to the Individual; and
 - (3) identifies the Individual or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual.
 PHI includes Protected Health Information that is transmitted by or maintained in electronic media.
- (g) Summary Health Information means information summarizing the claims history, claims expenses, or types of claims experienced by an Individual, and from which the following information has been removed:
 - (1) names;
 - (2) any geographic information which is more specific than a five-digit zip code;
 - (3) all elements of dates relating to a covered Individual (e.g., birth date) or any medical treatment (e.g., admission date) except the year; all ages for a covered Individual if the Individual is over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);
 - (4) other identifying numbers, such as, Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;
 - (5) facial photographs or biometric identifiers (e.g., fingerprints); and
 - (6) any other unique identifying number, characteristic, or code.

Section 15.02 HIPAA PRIVACY COMPLIANCE

The Plan's HIPAA privacy compliance rules ("Privacy Rule") are as follows:

- (a) Permitted Use or Disclosure of PHI by Plan Sponsor. Any disclosure to and use by the Plan Sponsor of any PHI will be subject to and consistent with this Section.
 - (1) The Plan and health insurance issuer, HMO, or Business Associate servicing the Plan may disclose PHI to the Plan Sponsor to permit the Plan Sponsor to carry out Plan Administration Functions, including but not limited to the following purposes:
 - (A) to provide and conduct Plan Administrative Functions related to payment and health care operations for and on behalf of the Plan;
 - (B) for auditing claims payments made by the Plan;
 - (C) to request proposals for services to be provided to or on behalf of the Plan; and
 - (D) to investigate fraud or other unlawful acts related to the Plan and committed or reasonably suspected of having been committed by a Plan participant.

ARTICLE 15 HIPAA PRIVACY AND SECURITY COMPLIANCE

- (2) The uses described above in (1) are permissible only if the Notice of Privacy Practices distributed to covered Individuals in accordance with the Privacy Rule states that PHI may be disclosed to the Plan Sponsor.
 - (3) The Plan or a health insurance issuer or HMO may disclose to the Plan Sponsor information regarding whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.
- (b) Restrictions on Plan Sponsor's Use and Disclosure of PHI.
- (1) The Plan Sponsor will not use or further disclose PHI, except as permitted or required by the Plan or as required by law.
 - (2) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides PHI agrees to the restrictions and conditions of this Section.
 - (3) The Plan Sponsor will not, and will not permit a health insurance issuer or HMO to, use or disclose PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
 - (4) The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.
 - (5) The Plan Sponsor will make a covered Individual's PHI available to the covered Individual in accordance with the Privacy Rule.
 - (6) The Plan Sponsor will make PHI available for amendment and will, upon notice, amend PHI in accordance with the Privacy Rule.
 - (7) The Plan Sponsor will track certain PHI disclosures it makes so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with the Privacy Rule.
 - (8) The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with the Privacy Rule.
 - (9) The Plan Sponsor will, if feasible, return or destroy all PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control) received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Individual who is the subject of the PHI, when that PHI is no longer needed for the Plan Administration Functions for which the disclosure was made. If it is not feasible to return or destroy all such PHI, the Plan Sponsor will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.
 - (10) When using or disclosing PHI or when requesting PHI from another party, the Plan sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.
 - (11) The Plan Sponsor will not use any genetic information for any underwriting purposes.
- (c) Adequate Separation between the Plan Sponsor and the Plan.
- (1) Only those employees of the Plan Sponsor as outlined in the Plan's HIPAA Policies and Procedures may be given access to PHI received from the Plan or a health insurance issuer, HMO or Business Associate servicing the Plan.
 - (2) The members of the classes of employees identified in the Plan's HIPAA Policies and Procedures will have access to PHI only to perform the Plan Administration Functions that the Plan Sponsor provides for the Plan.
 - (3) The Plan Sponsor will promptly report to the Plan any use or disclosure of PHI in breach, violation of, or noncompliance with, the provisions of this Section of the Plan, as required under this Section, and will cooperate with the Plan to correct the breach, violation or noncompliance, will impose appropriate disciplinary action or sanctions, including termination of employment, on each employee who is responsible for the breach, violation or noncompliance, and will mitigate any deleterious effect of the breach, violation or noncompliance on any Individual covered under the Plan, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. Regardless of whether a person is disciplined or terminated pursuant to this section, the Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor shall, modify or revoke any person's access to or use of PHI.
- (d) Purpose of Disclosure of Summary Health Information to Plan Sponsor.

ARTICLE 15 HIPAA PRIVACY AND SECURITY COMPLIANCE

- (1) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan.
- (2) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.
- (e) Plan Sponsor Certification. The Plan Sponsor will provide the Plan with a certification stating that the Plan has been amended to incorporate the terms of this Article and that the Plan Sponsor agrees to abide by these terms. The Plan Sponsor will also provide the certification upon request to its health insurance issuers, HMOs and Business Associates of the Plan.

Section 15.03 HIPAA SECURITY COMPLIANCE

To ensure the Plan's compliance with HIPAA's privacy compliance rules ("Security Rule"), the Plan Sponsor will:

- (a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- (b) Ensure that the adequate separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;
- (c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- (d) Report to the Plan any security incident of which it becomes aware.

The Plan Sponsor caused this Plan to be executed this 08 day of 01, 2023.

VANGUARD TRUCK HOLDINGS, LLC:

Signature: Stacy Stapleton

Print Name: Stacy Stapleton

Title/Position: HR Director

VANGUARD TRUCK HOLDINGS, LLC
FORMAL RECORD OF ACTION

The following is a formal record of action taken by the governing body of Vanguard Truck Holdings, LLC (the "Company").

With respect to the adoption of the Vanguard Truck Holdings, LLC Cafeteria Plan (the "Plan") by Tom Graddy Enterprises, LLC, Vanguard Truck Centers, LLC, Tom Graddy Enterprises of Savannah, LLC, Vanguard Truck Center of Houston, LLC, Tom Graddy Enterprises of Austin, LLC, Vanguard Truck Center of El Paso, LLC, Tom Graddy Enterprises of St. Louis, LLC, Arizona Truck Centers, LLC, Norwood Equipment, LLC and Vanguard Truck Center of North Carolina, LLC, the following resolutions are hereby adopted:

RESOLVED: That the Company hereby consents to the adoption of the Plan by Tom Graddy Enterprises, LLC, Vanguard Truck Centers, LLC, Tom Graddy Enterprises of Savannah, LLC, Vanguard Truck Center of Houston, LLC, Tom Graddy Enterprises of Austin, LLC, Vanguard Truck Center of El Paso, LLC, Tom Graddy Enterprises of St. Louis, LLC, Arizona Truck Centers, LLC, Norwood Equipment, LLC and Vanguard Truck Center of North Carolina, LLC;

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

Dated this 01 day of August, 2022.

Stacy Stapleton

Stacy Stapleton

HR Director

**TOM GRADDY ENTERPRISES, LLC
FORMAL RECORD OF ACTION**

The following is a formal record of action taken by Tom Graddy Enterprises, LLC (the "Company").

With respect to the adoption of the Vanguard Truck Holdings, LLC Cafeteria Plan (the "Plan") sponsored by Vanguard Truck Holdings, LLC, the following resolutions are hereby adopted:

RESOLVED: That the Company hereby adopts the Plan that is sponsored by Vanguard Truck Holdings, LLC;

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

Dated this 01 day of August, 2022.

Stacy Stapleton

Stacy Stapleton

HR Director

**VANGUARD TRUCK CENTERS, LLC
FORMAL RECORD OF ACTION**

The following is a formal record of action taken by Vanguard Truck Centers, LLC (the "Company").

With respect to the adoption of the Vanguard Truck Holdings, LLC Cafeteria Plan (the "Plan") sponsored by Vanguard Truck Holdings, LLC, the following resolutions are hereby adopted:

RESOLVED: That the Company hereby adopts the Plan that is sponsored by Vanguard Truck Holdings, LLC;

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

Dated this 01 day of August, 2022.

Stacy Stapleton

Stacy Stapleton

HR Director

**TOM GRADDY ENTERPRISES OF SAVANNAH, LLC
FORMAL RECORD OF ACTION**

The following is a formal record of action taken by Tom Graddy Enterprises of Savannah, LLC (the "Company").

With respect to the adoption of the Vanguard Truck Holdings, LLC Cafeteria Plan (the "Plan") sponsored by Vanguard Truck Holdings, LLC, the following resolutions are hereby adopted:

RESOLVED: That the Company hereby adopts the Plan that is sponsored by Vanguard Truck Holdings, LLC;

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

Dated this 01 day of August, 2022.

Stacy Stapleton

Stacy Stapleton

HR Director

VANGUARD TRUCK CENTER OF HOUSTON, LLC
FORMAL RECORD OF ACTION

The following is a formal record of action taken by Vanguard Truck Center of Houston, LLC (the "Company").

With respect to the adoption of the Vanguard Truck Holdings, LLC Cafeteria Plan (the "Plan") sponsored by Vanguard Truck Holdings, LLC, the following resolutions are hereby adopted:

RESOLVED: That the Company hereby adopts the Plan that is sponsored by Vanguard Truck Holdings, LLC;

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

Dated this 01 day of August, 2022.

Stacy Stapleton

Stacy Stapleton

HR Director

**TOM GRADDY ENTERPRISES OF AUSTIN, LLC
FORMAL RECORD OF ACTION**

The following is a formal record of action taken by Tom Graddy Enterprises of Austin, LLC (the "Company").

With respect to the adoption of the Vanguard Truck Holdings, LLC Cafeteria Plan (the "Plan") sponsored by Vanguard Truck Holdings, LLC, the following resolutions are hereby adopted:

RESOLVED: That the Company hereby adopts the Plan that is sponsored by Vanguard Truck Holdings, LLC;

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

Dated this 01 day of August, 2022.

Stacy Stapleton

Stacy Stapleton

HR Director

**VANGUARD TRUCK CENTER OF EL PASO, LLC
FORMAL RECORD OF ACTION**

The following is a formal record of action taken by Vanguard Truck Center of El Paso, LLC (the "Company").

With respect to the adoption of the Vanguard Truck Holdings, LLC Cafeteria Plan (the "Plan") sponsored by Vanguard Truck Holdings, LLC, the following resolutions are hereby adopted:

RESOLVED: That the Company hereby adopts the Plan that is sponsored by Vanguard Truck Holdings, LLC;

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

Dated this 01 day of August, 2022.

Stacy Stapleton

Stacy Stapleton

HR Director

TOM GRADDY ENTERPRISES OF ST. LOUIS, LLC
FORMAL RECORD OF ACTION

The following is a formal record of action taken by Tom Graddy Enterprises of St. Louis, LLC (the "Company").

With respect to the adoption of the Vanguard Truck Holdings, LLC Cafeteria Plan (the "Plan") sponsored by Vanguard Truck Holdings, LLC, the following resolutions are hereby adopted:

RESOLVED: That the Company hereby adopts the Plan that is sponsored by Vanguard Truck Holdings, LLC;

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

Dated this 01 day of August, 2022.

Stacy Stapleton

Stacy Stapleton

HR Director

ARIZONA TRUCK CENTERS, LLC
FORMAL RECORD OF ACTION

The following is a formal record of action taken by Arizona Truck Centers, LLC (the "Company").

With respect to the adoption of the Vanguard Truck Holdings, LLC Cafeteria Plan (the "Plan") sponsored by Vanguard Truck Holdings, LLC, the following resolutions are hereby adopted:

RESOLVED: That the Company hereby adopts the Plan that is sponsored by Vanguard Truck Holdings, LLC;

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

Dated this 01 day of August, 2022.

Stacy Stapleton

Stacy Stapleton

HR Director

**NORWOOD EQUIPMENT, LLC
FORMAL RECORD OF ACTION**

The following is a formal record of action taken by Norwood Equipment, LLC (the "Company").

With respect to the adoption of the Vanguard Truck Holdings, LLC Cafeteria Plan (the "Plan") sponsored by Vanguard Truck Holdings, LLC, the following resolutions are hereby adopted:

RESOLVED: That the Company hereby adopts the Plan that is sponsored by Vanguard Truck Holdings, LLC;

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

Dated this 01 day of August, 2022.

Stacy Stapleton

Stacy Stapleton

HR Director

VANGUARD TRUCK CENTER OF NORTH CAROLINA, LLC
FORMAL RECORD OF ACTION

The following is a formal record of action taken by Vanguard Truck Center of North Carolina, LLC (the "Company").

With respect to the adoption of the Vanguard Truck Holdings, LLC Cafeteria Plan (the "Plan") sponsored by Vanguard Truck Holdings, LLC, the following resolutions are hereby adopted:

RESOLVED: That the Company hereby adopts the Plan that is sponsored by Vanguard Truck Holdings, LLC;

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

Dated this 01 day of August, 2022.

Stacy Stapleton

Stacy Stapleton

HR Director

VANGUARD TRUCK HOLDINGS, LLC CAFETERIA PLAN

JOINDER AGREEMENT

WHEREAS, Vanguard Truck Holdings, LLC (the "Company") maintains the Vanguard Truck Holdings, LLC Cafeteria Plan (the "Plan") for the benefit of certain of its employees; and

WHEREAS, The Company desires to permit Tom Graddy Enterprises, LLC, Vanguard Truck Centers, LLC, Tom Graddy Enterprises of Savannah, LLC, Vanguard Truck Center of Houston, LLC, Tom Graddy Enterprises of Austin, LLC, Vanguard Truck Center of El Paso, LLC, Tom Graddy Enterprises of St. Louis, LLC, Arizona Truck Centers, LLC, Norwood Equipment, LLC and Vanguard Truck Center of North Carolina, LLC ("Adopting Employers") to adopt the Plan;

NOW, THEREFORE IT IS AGREED, that the undersigned Adopting Employers shall become a Company that has adopted the Plan and such Adopting Employer(s) agree to be bound by the terms of the Plan.

This Agreement shall be effective 08-01-2022

COMPANY:

Signed: Stacy Stapleton

TOM GRADDY ENTERPRISES, LLC:

Signed: Stacy Stapleton

VANGUARD TRUCK CENTERS, LLC:

Signed: Stacy Stapleton

TOM GRADDY ENTERPRISES OF SAVANNAH, LLC:

Signed: Stacy Stapleton

VANGUARD TRUCK CENTER OF HOUSTON, LLC:

Signed: Stacy Stapleton

TOM GRADDY ENTERPRISES OF AUSTIN, LLC:

Signed: Stacy Stapleton

VANGUARD TRUCK CENTER OF EL PASO, LLC:

Signed: Stacy Stapleton

TOM GRADDY ENTERPRISES OF ST. LOUIS, LLC:

Signed: Stacy Stapleton

ARIZONA TRUCK CENTERS, LLC:

Signed: Stacy Stapleton

NORWOOD EQUIPMENT, LLC:

Signed: Stacy Stapleton

VANGUARD TRUCK CENTER OF NORTH CAROLINA, LLC:

Signed: Stacy Stapleton

**VANGUARD TRUCK HOLDINGS, LLC
FORMAL RECORD OF ACTION**

The following is a formal record of action taken by the governing body of Vanguard Truck Holdings, LLC (the "Company").

With respect to the amendment of the Vanguard Truck Holdings, LLC Cafeteria Plan (the "Plan"), the following resolutions are hereby adopted:

RESOLVED: That the Plan be amended in the form attached hereto, which amendment is hereby adopted and approved;

RESOLVED FURTHER: That the appropriate officers of the Company be, and they hereby are, authorized and directed to execute said amendment on behalf of the Company;

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

Dated this __21__ day of ____July_____, 2025.

VANGUARD TRUCK HOLDINGS, LLC CAFETERIA PLAN

SUMMARY OF MATERIAL MODIFICATIONS

The purpose of this Summary of Material Modifications is to inform you of a change that has been made to the Vanguard Truck Holdings, LLC Cafeteria Plan. This change has affected the information previously provided to you in the Plan's Summary Plan Description. The Summary Plan Description is modified as described below.

Effective 08/01/2025, the maximum amount you may contribute each year to your General Purpose Health FSA and/or HSA-Compatible Health FSA is the maximum amount permitted under the tax code, \$3,300 for the 25-26 plan year.

Effective 08/01/2025, notwithstanding the forfeiture provisions above, if you have a balance in your Health FSA as of the last day of the Plan Year after all eligible expenses have been reimbursed and the claims deadline for the Plan Year has passed, the Plan will carry over the balance from your Health FSA, up to \$660.00, which may be used to pay or reimburse eligible expenses for the subsequent Plan Year.

IN WITNESS WHEREOF, the Company has caused this Amendment to be executed this __21__ day of __July_____, 2025.

VANGUARD TRUCK HOLDINGS, LLC:

Signature: Stacy Stapleton

Print Name: Stacy Stapleton

Title/Position: HR Director

VANGUARD TRUCK HOLDINGS, LLC CAFETERIA PLAN

SUMMARY PLAN DESCRIPTION

08/01/2023

VANGUARD TRUCK HOLDINGS, LLC CAFETERIA PLAN

SUMMARY PLAN DESCRIPTION

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INTRODUCTION

Vanguard Truck Holdings, LLC (the "Employer") established the Vanguard Truck Holdings, LLC Cafeteria Plan (the "Plan") 08/01/2023. The Plan is a cafeteria plan that provides an eligible employee with the opportunity to choose among benefits offered under the Plan.

This summary supersedes all previous summaries of the Plan. Although the purpose of this document is to summarize the more significant provisions of the Plan, it is only a summary - the terms of the Plan document ultimately govern the operation and administration of the Plan. The Employer and any employer who has adopted the Plan is referred to in this document as the "Employer".

ELIGIBILITY

You are an "Eligible Employee" if you are an employee of the Employer or any affiliate who has adopted the Plan on the first day of the calendar month coincident with or next following the date you have attained at least 18 years of age and you have completed at least 30 days of service.

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

- A self-employed individual (including a partner), or a person who owns (or is deemed to own) more than 2 percent of the outstanding stock of an S corporation.
- Covered by a collective bargaining agreement that does not provide for participation in this Plan.
- A leased employee.
- A non-resident alien who received no U.S. source earned income.
- A part-time employee who is expected to work fewer than 30 hours per week.

If you are eligible to participate in the Employer-sponsored group health plan, then you are eligible to participate in the Health Flexible Spending Account, even if you do not elect to participate in the Employer-sponsored group health plan.

If you elect to participate in the Health Savings Account (HSA) you are not eligible to participate in a Health FSA that is not an HSA-Compatible Health FSA.

If you are eligible to participate in the Employer-sponsored group health plan, then you are eligible to participate in the HSA-Compatible Health Flexible Spending Account, even if you do not elect to participate in the Employer-sponsored group health plan.

If you elect to participate in the General Health FSA then you are not eligible to contribute to an HSA-Compatible Health FSA, unless you elect to convert your General Health FSA. You must be enrolled in a high deductible health plan to be eligible to contribute to the Health Savings Account for the month. If you elect to participate in a General Health FSA for the Plan Year you are not eligible to participate in the HSA Benefit.

ELECTION PROCEDURES

You may elect to participate in the Benefits under the Plan within 30 days after your eligibility date (or a shorter period if established by the Plan Administrator).

If you do not enroll in the Plan upon your initial eligibility, you may enroll during the enrollment period established by the Plan Administrator. Your election will be effective as of the first day of the Plan Year following the enrollment period.

You may also enroll in the Plan upon a change in status event as described below.

To enroll in the Plan, you may need to submit a completed election form to the Plan Administrator on or before the date specified by the Plan Administrator. If, as of the start of a Plan Year, you have not submitted a completed election form by its due date, you will be deemed to have elected not to participate in the Plan for that Plan Year.

If you fail to submit an election form, prior year elections will automatically apply to the following benefits: Premium Conversion Account and HSA Account. An election to participate in the Plan is generally irrevocable for the Plan Year except for the HSA Benefit, described below. You may not change your election during a Plan Year unless you experience a change in status. Your change in election must be on account of and correspond with a change in status that affects your eligibility for coverage under the Plan.

Depending on the Benefit, a "change in status" includes:

- Change in your marital status.
- Change in the number of your dependents.

- Change in your employment status or the employment status of your spouse or dependents.
- Your dependent satisfies or ceases to satisfy eligibility requirements.
- Change in your place of residence.
- Commencement or termination of an adoption proceeding.
- Court judgment, decree, or order.
- Entitlement to Medicare or Medicaid by you, your spouse, or your dependent.
- Significant cost or other coverage changes.
- You change coverage under another cafeteria plan.
- You take leave under the FMLA.
- You lose coverage under the group health plan due to a reduction in hours.
- You are eligible to enroll in a qualified health plan through the Marketplace.

BENEFITS

Contributions pertaining to a Benefit will be credited to the applicable account. Your contributions to the Plan are not subject to federal income tax or social security taxes. Please note that while you may enjoy certain tax benefits, there may be some drawbacks to participation in the Plan. For instance, participation in the Plan may lower your social security benefits. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

If you are a highly paid employee or an owner of your Employer, federal law may impose limits on your behalf to participate in the Plan and/or the benefits you may receive from the Plan. If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify your election in order to assure compliance with such requirements or limitations.

Premium Conversion Account

If you elect to contribute to a Premium Conversion Account, the Plan will establish a Premium Conversion Account in your name. Your Premium Conversion Account will be credited with amounts withheld from your compensation. The amount of the contribution to your Premium Conversion Account is equal to the amount of your portion of the premium due for the following benefits/contracts:

- Employer Health
- Employer Dental
- Employer Vision
- Supplemental Benefits

In addition, your election for your premiums will be automatically adjusted for any change in the cost of contracts sponsored by the Employer as permitted by applicable law.

If you affirmatively elect not to participate in the Premium Conversion Account for a Plan Year, you will not be enrolled unless and until you elect to participate in the Premium Conversion Account as described in the "Election Procedures" above. Contributions to the Premium Conversion Account are not subject to federal income tax or social security taxes.

In the event of a conflict between the terms of this Plan and the terms of the applicable contract, the terms of the contract (or the benefit plan under which it is established) will control.

Health Flexible Spending Account (Health FSA)

The following Health Flexible Spending Account is available under the Plan:

- General Purpose Health FSA
- Limited Purpose Health FSA

General Purpose Health FSAs may only be used to reimburse for qualifying medical expenses during the Plan Year.

Limited Purpose Health FSAs may only be used to reimburse expenses incurred for qualifying dental or vision care or preventative care and are typically used in conjunction with a high-deductible group health plan. A Limited Purpose Health FSA is intended to qualify as an "HSA-Compatible Health FSA."

If you are eligible, you may elect to contribute to a Health FSA in accordance with the "Election Procedures" described above.

Health FSA Eligibility

Please be aware that there are some limitations on your eligibility to participate in Health FSAs. If you are an Eligible Employee, you are eligible to contribute to a Health FSA. However, if you are not eligible to participate in the Employer-sponsored group health plan, then you are not eligible to participate in a Health FSA.

You cannot participate in a General Purpose Health FSA and a Limited Purpose FSA simultaneously. If you elect to participate in the General Purpose Health FSA then you are not eligible to contribute to a Limited Purpose Health FSA, unless you elect to convert your General Purpose Health FSA as described below. Similarly, if you elect to participate in the Limited Purpose Health FSA you are not eligible to participate in the General Purpose Health FSA Benefit.

Additionally, if you elect to participate in the Health Savings Account you are not eligible to participate in the General Purpose Health FSA Benefit.

Conversion to an HSA-Compatible Health FSA

If a Participant who has elected a General Purpose Health FSA for a given Plan Year establishes a Health Savings Account under the Plan or otherwise for the subsequent Plan Year, they may elect (or will be deemed by the Plan Administrator to have elected), as of the last day of the Plan Year (the "Conversion Date") to carryover the balance in their General Purpose Health FSA to an available HSA-Compatible Health FSA for the subsequent Plan Year. An HSA-Compatible Health FSA may not be converted into a General Purpose Health FSA.

Health FSA Contributions

Your Health FSA will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount you may contribute each year to your General Purpose Health FSA and/or HSA-Compatible Health FSA is the maximum amount permitted under the tax code (\$3,050 for 2023). The Employer will not make additional contributions to your General Purpose Health FSA or your HSA-Compatible Health FSA on your behalf.

Health FSA Eligible Expenses/Reimbursement

You will be entitled to receive reimbursement from your General Purpose Health FSA for eligible expenses incurred by you, your spouse and dependents, if any. A dependent is generally someone you may claim as a dependent on your federal tax return and also includes a child until their 26th birthday. The entire annual amount you elect to contribute for the Plan Year to your Health FSA, less any reimbursements already distributed from your Health FSA, will be available for reimbursement throughout the Plan Year.

You may receive reimbursement for eligible expenses incurred during the Plan Year when you are participating in your Health FSA. Eligible expenses generally include all medical expenses that you may deduct on your federal income tax return. Health insurance premiums are not an eligible expense for the Health FSA.

You will not be reimbursed for any expenses that were (1) incurred before you are eligible to participate in the Health FSA; (2) incurred after you have become ineligible to participate in the Health FSA and are attributable to a tax deduction you took in a prior taxable year; or (3) covered, paid, or reimbursed from another source. Your claim for reimbursement must include substantiation that the Plan Administrator or Claims Administrator considers sufficient for determining that the claim constitutes an expense eligible for reimbursement under the Plan.

You must submit claims for reimbursement from your General Purpose Health FSA and HSA-Compatible Health FSA no later than 90 days after the end of the Plan Year. Any amounts remaining in your Health FSA after all timely claims have been paid will be forfeited.

Notwithstanding the forfeiture provisions above, if you have a balance in your Health FSA as of the last day of the Plan Year after all eligible expenses have been reimbursed and the claims deadline for the Plan Year has passed, the Plan will carry over the balance from your General Purpose Health FSA, up to \$610.00, and from your HSA-Compatible Health FSA, up to \$610.00, which may be used to pay or reimburse eligible expenses for the subsequent Plan Year. Any amounts in your Health FSA that exceed the limit above will be forfeited.

Termination of Employment

If you terminate employment with the Employer for any reason during the Plan Year, your contributions to your FSA will end as of your date of termination. You may submit claims for reimbursement from your FSA for expenses incurred during the Plan Year prior to your termination of employment. You must submit claims for reimbursement from your Health FSA no later than 90 days after the date your employment terminates. Any balance remaining in your Health FSA will be forfeited after claims submitted prior to this date have been processed.

Qualified Reservist Distributions

If you are a military reservist called to active duty for a period in excess of 179 days or for an indefinite period, you may elect to receive a distribution from your Health FSA up to an amount equal to the amount you have contributed to the applicable FSA for the Plan Year, minus reimbursements paid as of the date of the distribution request. You must make the distribution request during the period beginning on the date of your call-up and ending on the last date that reimbursements could otherwise be made for that Plan Year.

Dependent Care Assistance Plan Account (DCAP)

A Dependent Care Assistance Plan Account may be used to reimburse expenses incurred for the care of a qualifying dependent. If you are eligible, you may elect to contribute to a DCAP Account in accordance with the "Election Procedures" described above.

DCAP Contributions

Your DCAP Account will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount that you may contribute each year to your DCAP Account is the maximum amount permitted under the tax code (\$5,000 for 2023, \$2,500 if you are married and filing separately.) The Employer will not make additional contributions to your DCAP Account on your behalf.

DCAP Eligible Expenses/Reimbursement

The amount available for reimbursement is the balance in your DCAP Account at the time the reimbursement request is received by the Plan Administrator or Claims Administrator. You may receive reimbursement for eligible expenses incurred during the Plan Year when you are participating in your DCAP Account. Eligible expenses generally include those that you incur in order to be gainfully employed and for the care of (i) your dependent who is under age 13, or (ii) your spouse or dependent who lives with you and who is physically or mentally incapable of caring for themselves. Expenses incurred for overnight camp are not eligible for reimbursement. A dependent is generally someone who you may claim as a dependent on your federal tax return.

You must submit claims for reimbursement from your DCAP Account no later than 90 days following the Plan Year. Any amounts remaining in your DCAP Account at the end of the Plan Year after all timely claims have been paid will be forfeited.

Termination of Employment

If you terminate employment with the Employer for any reason during the Plan Year, your contributions to your DCAP Account will end as of your date of termination. You may submit claims for reimbursement from your DCAP Account for expenses incurred during the Plan Year prior to your termination of employment. You must submit claims for reimbursement from your DCAP Account no later than 90 days after the date your employment terminates. Any balance remaining in your DCAP Account will be forfeited after claims submitted prior to this date have been processed.

Health Savings Account (HSA)

A Health Savings Account may be used to reimburse qualifying medical expenses. If you are eligible, you may elect to contribute to an HSA in accordance with the "Election Procedures" described above.

HSA Eligibility

If, as of the first day of the month, you are enrolled in a high deductible health plan, you are eligible to participate in the Health Savings Account for the month. Your participation in a General Purpose Health FSA under another plan may also affect your ability to contribute to an HSA. If you are not enrolled in a high deductible health plan or are covered under a non-high deductible health plan you are not eligible to contribute to an HSA.

HSA Contributions

Your HSA will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount you may contribute each year to your HSA is the maximum amount permitted under the tax code (\$3,850 for 2023, if you are enrolled in self-only coverage and \$7,750 for 2023 if you are enrolled in family coverage).

If the Employer decides to make a contribution to your HSA, the amount of the contribution and the method used to allocate the contribution among various participants will be determined by the Employer at the time the contribution is made.

HSA Eligible Expenses/Reimbursement

Your HSA Benefit is not an employer-sponsored employee benefit plan - it is an individual trust or custodial account separately established and maintained outside the Plan. Consequently, the Employer does not establish or maintain the HSA. The Plan Administrator will maintain records to keep track of your HSA contributions, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in your HSA.

Termination of Employment

If you terminate employment with the Employer for any reason during the Plan Year, your contributions to your HSA will end as of your date of termination. You will continue to be eligible to receive distributions from your HSA in accordance with the terms of the documents governing your HSA.

CLAIMS PROCEDURES

You must submit your claim for benefits in accordance with the Plan Administrator's guidelines. Claims may also be submitted to Consolidated Admin Services, LLC at P.O. Box 1513, Cabot, Arkansas 72023. The telephone number is 877-941-5956.

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

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

Claims for Plan Benefits (except for Health FSAs)

You must file a claim for benefits under this Plan in accordance with the Plan Administrator's guidelines. If your claim does not include enough information to process the claim, you will be given an opportunity to provide the missing information. You may designate an authorized representative by providing written notice of the designation to the Plan Administrator.

You may apply for benefits under the Plan by completing and filing a claim with the Plan Administrator. Your claim must include all information and evidence that the Plan Administrator deems necessary to evaluate the merit of your claim and to make any necessary determinations on your claim. The Plan Administrator may request any additional information from you as necessary to evaluate the claim.

Claims for Health FSA Benefits

If you file a claim for benefits from your Health FSA and that claim is denied, the Plan Administrator will notify you within a reasonable period of time, but no later than 30 days after the Plan Administrator received the claim. The Plan Administrator may notify you, prior to the expiration of this 30-day period, of the need to extend the period by up to 15 days due to matters beyond its control. In such case the Plan Administrator will notify you of the circumstances requiring the extension of time and the date by which the Plan Administrator will notify you of its decision. If the extension is necessary because you did not submit information necessary to decide the claim, the notice of extension will describe the required information, and you will have at least 45 days from the day you receive the notice to provide the specified information.

If your claim is denied, the Plan Administrator will provide you with a notice identifying (A) the reason or reasons for the denial, (B) the Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that you must take if you wish to appeal the denial, including a statement that you may bring a civil action under ERISA after following the Plan's claims procedures. The notice will also include (1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or (2) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Appeal of Denied Claim. If you wish to appeal the denial of a claim, you must file an appeal with the Plan Administrator on or before the 180th day after you receive the Plan Administrator's notice that the claim has been denied. You will lose the right to appeal if the appeal is not made within this 180-day period. The appeal must identify both the grounds and specific Plan provisions upon which the appeal is based. You will be provided, upon request and free of charge, documents and other information relevant to your claim. Your appeal may also include any comments, statements or documents that you desire to provide. The Plan Administrator will consider the merits of your presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. In considering the appeal, the Plan Administrator will:

- (A) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the denial that is the subject of the appeal, nor the subordinate of such individual;
- (B) Provide that, in deciding an appeal of any denial that is based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- (C) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether the advice was relied upon in making the denial; and
- (D) Provide that the health care professional engaged for purposes of a consultation under (B) above will be an individual who is neither an individual who was consulted in connection with the denial that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator will notify you of the Plan's benefit determination on review within 60 days after receipt by the Plan of your request for review of the denial.

Denial of Appeal. If your appeal is denied, the Plan Administrator will provide you with a notice identifying (A) the reason or reasons for such denial, (B) the Plan provisions on which the denial is based, (C) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and (D) a statement describing your right to bring an action under section 502(a) of ERISA after following the Plan's claims procedures. The determination rendered by the Plan Administrator shall be binding upon all parties.

Exhaustion of Remedies; Limitations Period for Filing Suit. Before you can file a lawsuit for benefits under the Plan, you must exhaust the Plan's internal remedies. A lawsuit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Benefits Provided under Contracts. Please see the underlying contracts for any additional claims and reimbursement rules under those contracts.

Debit/Credit Cards

Vanguard Truck Holdings, LLC will provide you with a debit/credit and/or other stored-value card for purposes of making purchases that are eligible for reimbursement from your Health Flexible Spending Account, Limited Purpose Health Flexible Spending Account and/or Dependent Care Assistance Plan Account. The Plan Administrator will provide you with more information about these cards as well as any limitations at the time you enroll in the Plan. You do not have to use the cards and may request reimbursements as listed above.

Claims Not Governed by this Summary

HSA Claims. Claims relating to the HSA are administered by your HSA trustee/custodians in accordance with the HSA trust or custodial document.

COBRA CONTINUATION COVERAGE

If you are participating in the Health FSA and your Employer is not a small employer, then COBRA applies. A "small employer" is generally an employer that employs fewer than 20 employees, but you should contact the Plan Administrator who can inform you if the Employer is a small employer not subject to COBRA and is not required to comply with these rules. Depending on your Health FSA balance at the time of the Qualifying Event (described below), you may not be eligible for COBRA continuation coverage.

Qualifying Events

You have the right to continue your coverage under the Health FSA if any of the following events results in your loss of coverage under the Health FSA:

- termination of employment for any reason other than gross misconduct
- reduction in your hours of employment

Your spouse and dependent children (including children born to you or placed for adoption with you) have the right to continue coverage under the Health FSA if any of the following events results in their loss of coverage under the Health FSA:

- termination of your employment for any reason other than gross misconduct
- reduction in your hours of employment
- you become enrolled in Medicare
- you and your spouse divorce or are legally separated
- your death
- your dependent ceases to be a "dependent child" for purposes of COBRA

Persons entitled to continue coverage under COBRA are "Qualified Beneficiaries."

If the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available under the Health FSA for the remainder of the Plan Year, you, your spouse, and/or your dependent child(ren) generally do not have the right to elect COBRA continuation coverage. You will be provided notice which explains your rights regarding COBRA continuation coverage.

Continuing Coverage

You may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

You, your spouse, or your dependent child(ren) must notify the Plan Administrator or its delegate in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days after the later of (1) the date of the Qualifying Event or (2) the date on which coverage is lost under the Plan because of the event. After receiving notice of a Qualifying Event, the Plan Administrator will provide Qualified Beneficiaries with an election notice, which describes the right to COBRA continuation coverage and how to make an election. Notice to your spouse is deemed notice to your covered dependents that reside with the spouse.

You or your dependent(s) are responsible for notifying the Plan Administrator or its delegate if you or your dependent(s) become covered under another group health plan or entitled to Medicare.

Election Procedures and Deadlines

A Qualified Beneficiary may make an election for COBRA continuation coverage if they are not covered under the Plan as a result of another Qualified Beneficiary's COBRA continuation election. To elect COBRA continuation coverage, you must complete the applicable election form within 60 days from the later of (1) the date the election notice was provided to you or (2) the date that the Qualified Beneficiary would otherwise lose coverage under the Plan due to the Qualifying Event and submit it to the Plan Administrator or its delegate. If the Qualified Beneficiary does not return the election form within the 60-day period, it will be considered a waiver of their COBRA continuation coverage rights.

Cost of COBRA Continuation Coverage

The cost of COBRA continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage.

When Continuation Coverage Ends

You may be able to continue coverage under the Health FSA until the end of the Plan Year in which the Qualifying Event occurs. However, COBRA continuation coverage may end earlier for any of the following reasons:

- You fail to make a required COBRA continuation coverage contribution;
- The date that you first become covered under another Health FSA;
- The date that you first become entitled to Medicare; or
- The date the Employer no longer provides a Health FSA to any of its employees.

YOUR RIGHTS UNDER ERISA

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for an ERISA welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of ERISA plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court if you have exhausted the Plan's claims procedures. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court if you have exhausted the Plan's claims procedures. If you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

MISCELLANEOUS

FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving health care benefits. Contact the Plan Administrator for more information under the Plan.

Unclaimed Reimbursements

Payments from the Account that are not claimed on a timely basis (for example, checks issued from the Plan that are not timely cashed) will be forfeited and returned to the Plan. Please contact your Plan Administrator about what constitutes "timely" claims of payment from the Plan.

Excess Payments/Reimbursements

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

Beneficiaries

If you die, your beneficiaries or your estate may submit claims for eligible expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose. If you do not name a beneficiary, the Plan Administrator may pay any amount to your spouse, one or more of your dependents, or a representative of your estate.

Qualified Medical Child Support Orders

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

Loss of Benefit

You may lose all or part of your Account(s) under the Plan if the unused balance is forfeited at the end of a Plan Year and if we cannot locate you when your benefit becomes payable to you.

Non-Alienation of Benefits

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a beneficiary to receive benefits under the Plan in the event of your death.

Amendment and Termination of the Plan

The Employer may amend or terminate the Plan at any time.

Plan Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding on all persons and parties.

Taxation

The Employer intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the Employer does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

Governing Law

The Plan is governed by the laws of Georgia to the extent not pre-empted by Federal law.

PLAN INFORMATION

1. The Plan Sponsor and Plan Administrator is Vanguard Truck Holdings, LLC.
2. The Plan Sponsor's and Plan Administrator's Address is 34 Old Ivy Road, Suite 200, Atlanta, Georgia 30224.
3. The Plan sponsor's EIN is 58-2511061.
4. The Plan Sponsor and Plan Administrator's phone number is 404-963-9160.
5. The Plan is a cafeteria plan under section 125 of the Internal Revenue Code. The Health FSA Benefit under the Plan is a welfare benefit plan.
6. The Plan number is 501.
7. The Plan's designated agent for service of legal process is the Plan Sponsor. Any legal papers should be delivered to the Plan Sponsor at the address listed above. However, service may also be made upon the Plan Administrator.
8. The Plan Year is the 12-consecutive month period ending on 07/31.
9. Amount contributed by Plan Participants and the Employer to the Plan are general assets of the Employer. All payments of benefits under the Plan are made solely out of the general assets of the Employer. The Employer has no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. The Employer may, in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making benefit payments under this Plan.