RYMAN HOSPITALITY PROPERTIES
EMPLOYEE HEALTH AND WELFARE PLAN

includes the
FLEXIBLE BENEFITS PLAN

AMENDED AND RESTATED
EFFECTIVE AS OF January 1, 2026

TABLE OF CONTENTS

ARTICLE I.
INTRODUCTION

1.01 History and Amendment and Restatement of the Plan.

Gaylord Entertainment Company ("Gaylord") historically maintained the Gaylord Entertainment Company Employee Health and Welfare Plan (plan number 507), as such was amended from time to time.

Effective as of October 1, 2012, Gaylord was renamed Ryman Hospitality Properties, Inc., and the Gaylord Entertainment Company Employee Health and Welfare Plan was renamed Ryman Hospitality Properties, Inc. Employee Health and Welfare Plan (plan number 507), which has been amended since that time.

The Company is a subsidiary of Ryman Hospitality Properties, Inc. As a result of recent changes to Ryman Hospitality Properties, Inc.'s size and structure, effective as of January 1, 2026 (the "Restatement Effective Date"), except as otherwise specifically provided herein, the Company now desires to further amend and restate the Ryman Hospitality Properties, Inc. Employee Health and Welfare Plan, to:

(a) assume sponsorship of the Plan

(b) rename the plan the Ryman Hospitality Properties Employee Health and Welfare Plan (plan number 507) (the "Plan"); and

(c) provide for the Plan's continuation under the terms and conditions set forth herein.

The documents listed from time to time in Appendix A ("Coverage Documents") describe in detail the various welfare benefits available from time to time under the Plan.

1.02 Purposes of the Plan.

A purpose of this Plan is to provide various welfare (including certain group health plan) benefits to eligible employees (and for their eligible dependents and other beneficiaries, as applicable), subject to the terms and conditions of the Plan.

Other purposes of this Plan include: (i) to provide eligible employees with a choice between certain taxable and nontaxable benefits according to the needs of each Employee, as set forth in Article VI (the "Flexible Benefits Plan"); (ii) to provide eligible employees with reimbursements for Qualifying Medical Care Expenses (as such term is defined in Article II) that are excludable from the employees' gross incomes under Section 105(b) of the Internal Revenue Code of 1986, as amended (the "Code"), as set forth in Article VII (the "Health Flexible Spending Accounts"); and (iii) to provide eligible employees with reimbursements for Dependent Care Expenses (as such term is defined in Article II) that are excludable from the employees' gross incomes under Section 129 of the Code, as set forth in Article VIII (the "Dependent Care Flexible Spending Account").

1.03 Plan Status.

This Plan, other than the Flexible Benefits Plan and the Dependent Care Flexible Spending Account thereunder, is an employee welfare benefit plan within the meaning of Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and this Plan document is intended, together with the Coverage Documents, to be the written instrument pursuant to which the Plan is established and maintained within the contemplation of Section 402 of ERISA.

In the event any term, provision, implication, or statement in a Coverage Document conflicts with, contradicts, or renders ambiguous a term, provision, implication, or statement in this document, such term, provision, implication, or statement in this document shall control, except to the extent necessary to give effect to the terms of an Insurance Contract (as such term is defined in Article II) or applicable law.

Notwithstanding anything therein to the contrary, the Flexible Benefits Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Code, and is to be interpreted in a manner consistent therewith.

Additionally, the (i) Health Care Flexible Spending Account and Limited Use Flexible Spending Account (collectively, the "Health Flexible Spending Accounts") and (ii) Dependent Care Flexible Spending

Account are intended to qualify, respectively, as (i) "self-insured medical reimbursement plans" under Section 105(h)(6) of the Code, and (ii) a "dependent care assistance program" under Section 129(d) of the Code; and the Plan is to be interpreted in manners consistent therewith.

Further, the Plan will be operated in a nondiscriminatory manner as required by Sections 79, 105(h), 125, and 129, as applicable, and any other applicable sections, of the Code (and other applicable law), and the Plan Administrator and/or the Employer shall take whatever steps as are necessary to so maintain the Plan.

1.04 Applicability of Prior Plan.

The rights and benefits, if any, of an individual who is a Participant (as such term is defined in Article II) or former Participant (or beneficiary) on or after the Restatement Effective Date shall be determined in accordance with the provisions of the Plan, except as otherwise provided herein. The provisions of this Plan supersede and replace any and all other prior plan documents providing similar benefits to Participants and former Participants (and/or their beneficiaries, as applicable).

ARTICLE II.
DEFINITIONS

Each word, term, and phrase listed in this Article II shall have the following meaning whenever such word, term, or phrase is capitalized and used in any article or appendix of this Plan unless the context clearly indicates otherwise. Any other defined term shall have the meaning specified in the article in which it hereafter appears.

2.01 Administrative Services Agreement

If applicable, an administrative services only or similar agreement, by whatever name called, between a Claims Administrator and the Company whereby the Claims Administrator agrees to provide certain administrative services stipulated therein in connection with the administration of a self-insured welfare or other benefit program maintained by the Company.

2.02 Adverse Benefit Determination

Any of the following: denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's (or beneficiary's) eligibility to participate in the Plan, and including, with respect to Group Health Plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

To the extent required by the Affordable Care Act, the term "Adverse Benefit Determination" also includes a Rescission of coverage with respect to a Participant or beneficiary, whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time.

The term "Adverse Benefit Determination" also includes any Rescission of disability coverage with respect to a Participant or beneficiary, whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time.

2.03 Affiliated Employer

Any corporation or other entity that is a member of a controlled group of corporations (as defined in Section 414(b) of the Code) that includes the Company, any trade or business (whether or not incorporated) that is under common control (as defined in Section 414(c) of the Code) with the Company, any organization (whether or not incorporated) that is a member of an affiliated service group (as defined in Section 4l4(m) of the Code) that includes the Company, and any other entity required to be aggregated with the Company pursuant to regulations under Section 414(o) of the Code.

2.04 Affordable Care Act

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 and as subsequently amended from time to time.

2.05 Benefit Option

Each of those optional benefit choices designated from time to time in Appendix B, the premiums or contributions for which are eligible for salary reduction under the Flexible Benefits Plan.

2.06 Benefits Trust Committee

The Ryman Hospitality Properties, Inc. Benefits Trust Committee, appointed by the Human Resources Committee of the Board of Ryman Hospitality Properties, Inc.

2.07 Board

The board of directors or members, or other applicable governing body, of the Company (or other Employer, as applicable).

2.08 Change in Status Event

Any of the following events (as set forth in 26 C.F.R. § 1.125-4(c)(2)) or other events as may be permitted by applicable regulations and other guidance with respect thereto under Section 125 of the Code:

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

(b) Number of Dependents. Events that change a Participant's number of Dependents, including by birth, adoption, legal guardianship, placement for adoption, or death of a Dependent.

(c) Employment Status. Any of the following events that changes the employment status of the Participant or the Participant's Dependent (including a Spouse): 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, as well as any other change in the individual's employment status that results in the individual becoming (or ceasing to be) eligible under a benefit plan of the individual's employer.

(d) Dependent Satisfies or Ceases to Satisfy Eligibility Requirements. An event that causes the Participant's Dependent to satisfy or cease to satisfy eligibility requirements for coverage due to attainment of age, student status, or any similar circumstance.

(e) Residence. A change in the place of residence of the Participant or the Participant's Dependent (including a Spouse).

2.09 CHIP

The state children's health insurance program under Title XXI of the Social Security Act.

2.10 CHIPRA

The Children's Health Insurance Program Reauthorization Act of 2009, as amended from time to time.

2.11 Claim Involving Urgent Care

A claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care claim determinations (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is a "Claim Involving Urgent Care" within the meaning of the preceding paragraph is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Notwithstanding the foregoing, any claim that a physician with knowledge of the claimant's medical condition determines is a "Claim Involving Urgent Care" shall be treated as a Claim Involving Urgent Care for purposes of Article XI; and, to the extent required by the Affordable Care Act, the Plan shall defer to the determination of the attending provider in this regard.

2.12 Claims Administrator

If applicable, an administrator that is party to an Administrative Services Agreement; otherwise, it shall mean the Insurer.

2.13 COBRA

Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

2.14 Code

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

2.15 Company

Ryman Corporate Properties, LLC, a Delaware limited liability company, or any successor thereto.

2.16 Compensation

The total wages or salary paid to a Participant during a Plan Year for personal services rendered in the course of employment with an Employer, but determined prior to (a) any salary reductions pursuant to the Flexible Benefits Plan or any other plan(s) maintained or adopted by the Employer pursuant to Section 125 of the Code, and (b) any salary deferral elections under any plan or arrangement under Section 132(f)(4) of the Code; but determined after any salary deferral elections under any plan or arrangement under Sections 401(k), 403(b), 408(k), and/or 457(b) of the Code. Thus, "Compensation" generally means wages or salary paid to an Employee by the Employer as reported in Box 1 of IRS Form W-2, but adding back in any wages or salary by virtue of any election described in (a) or (b) of the preceding sentence.

2.17 Coverage Documents

The applicable summary plan descriptions, Insurance Contracts, and/or other written documents designated from time to time in Appendix A hereto pursuant to which the welfare benefits of the Plan are provided and which, by this reference, are incorporated herein.

2.18 Covered Person

Any Participant or any covered Dependent.

2.19 Dependent

(a) Welfare Benefits in General. Except as otherwise provided below in subsections (b), (c), and (d), for the purpose of each of the welfare benefits offered under the Plan, "Dependent" shall mean the Participant's spouse or Domestic Partner, child(ren), and/or other individual(s) described as being in an eligible "dependent" class in the applicable Coverage Document and/or in the enrollment materials (to the extent such enrollment materials are not inconsistent with an applicable Insurance Contract or other Coverage Document(s)). Notwithstanding anything in the applicable Coverage Document(s) to the contrary and to the extent required by the Affordable Care Act, for purposes of the Plan provisions relating to coverage of children under any group health plan that does not constitute an Excepted Benefit and that provides dependent coverage of children, "Dependent" shall include a "child" (as defined in Section 152(f)(1) of the Code) of the Participant who has not attained age 26.

(b) Flexible Benefits Plan. For the purpose of the Flexible Benefits Plan (except as otherwise provided in subsections (c) and (d) below), "Dependent" shall mean any individual who qualifies as a "dependent" under the particular Benefit Option and who also qualifies as either (i) the Spouse of the Participant or (ii) a dependent of the Participant under Section 152 of the Code as modified by Section 105(b) of the Code. This includes any "child" (as defined in Section 152(f)(1) of the Code) of the Participant who, as of the end of the Plan Year, has not attained age 27.

(c) Health Flexible Spending Accounts. For purposes of the Health Flexible Spending Accounts, "Dependent" shall mean any individual who qualifies as (i) the Spouse of the Participant or (ii) a dependent of the Participant under Section 152 of the Code as modified by Section 105(b) of the Code. This includes any "child" (as defined in Section 152(f)(1) of the Code) of the Participant who, as of the end of the Plan Year, has not attained age 27. Further, any child to whom Section 152(e) of the Code applies (having to do with special rules for divorced parents) shall be treated as a Dependent of both parents for purposes of the Health Flexible Spending Accounts.

(d) Dependent Care Flexible Spending Account. For the purpose of the Dependent Care Flexible Spending Account, "Dependent" shall mean any individual who is: (i) a dependent of the Participant as defined in Section 152(a)(1) of the Code (generally a child, sibling, niece, nephew, or similar person who lives with the Participant and who does not provide more than one-half of their own support) who is under the age of 13 and with respect to whom the Participant is entitled

to an exemption under Section 151(c) of the Code; or (ii) a dependent (as defined in Section 152 of the Code, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) or Spouse of the Participant who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than one-half of the Participant's taxable year. Also for purposes of the Dependent Care Flexible Spending Account, "Dependent" shall include a qualifying individual as defined in Section 21(b)(1) of the Code with respect to the Participant and in the case of divorced parents, the child shall, as provided in Section 21(e)(5) of the Code, be treated as a qualifying individual of the custodial parent (within the meaning of Section 152(e) of the Code), and shall not be treated as a qualifying individual with respect to the non-custodial parent.

Notwithstanding any of the foregoing, the Plan will provide group health plan benefits in accordance with the applicable requirements of any QMCSO.

2.20 Dependent Care Expenses

The expenses incurred by a Participant that (i) are incurred for the care of a Dependent of the Participant, including incidental household services; (ii) are paid or payable to a Dependent Care Service Provider; and (iii) are incurred to enable the Participant (and the Participant's Spouse, if any) to be "gainfully employed" within the meaning of Section 21 of the Code (e.g., working or looking for work, or a full-time student) for any period for which there are one or more Dependents with respect to the Participant.

"Dependent Care Expenses" shall not include expenses incurred for (i) services outside the Participant's household for the care of a Dependent, unless such Dependent is described in Section 21(b)(1)(A) of the Code or regularly spends at least 8 hours each day in the Participant's household, or (ii) services at a camp where the Dependent stays overnight.

Dependent Care Expenses generally shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

2.21 Dependent Care Flexible Spending Account

The portion of the Plan set forth in Article VIII. The Dependent Care Flexible Spending Account is a part of the Flexible Benefits Plan. The Dependent Care Flexible Spending Account is also commonly known as the Dependent Care FSA.

2.22 Dependent Care Service Provider

A person who provides care or other services described in the "Dependent Care Expenses" definition above, but that shall not include: (i) a dependent care center (as defined in Section 21(b)(2)(D) of the Code), unless the requirements of Section 21(b)(2)(C) of the Code are satisfied; or (ii) a related individual described in Section 129(c) of the Code.

2.23 Domestic Partner

An individual who is the "domestic partner" of the Eligible Employee within the meaning of the Ryman Hospitality Properties, Inc. Domestic Partner Policy, and who, with respect to any particular benefit(s) provided pursuant to an Insurance Contract, also meets any applicable requirements of the Insurer.

2.24 Effective Date

With respect to any particular benefit, the date on which a Participant completes their eligibility or waiting period, if any, as specified in the applicable Coverage Document and/or in the enrollment materials (to the extent such enrollment materials are not inconsistent with an applicable Insurance Contract or other Coverage Document(s)).

2.25 Election Period

The period preceding the beginning of each Plan Year as designated by the Plan Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Eligible Employees and Participants; provided, however, that an Employee's initial Election Period shall be determined pursuant to Section 6.08.

2.26 Eligible Employee

(a) Welfare Benefits in General. Except as provided in subsection (b), the term "Eligible Employee" shall mean an Employee and any other employee who meets the applicable eligibility requirements of the Plan, as described in the applicable Coverage Document(s) and/or the enrollment materials in accordance with Article III hereof.

(b) Flexible Benefits Plan. With respect to the Flexible Benefits Plan (including the Flexible Spending Accounts offered thereunder), the term "Eligible Employee" shall mean an Employee who meets the eligibility requirements of the Flexible Benefits Plan in accordance with Article III hereof.

The term "Eligible Employee" shall include an individual who was formerly an Eligible Employee (as defined above in this section) for the limited purpose of allowing continued eligibility for benefits under the Plan, but only to the extent such participation is permitted by the Plan (including in the applicable Coverage Document(s)).

Notwithstanding anything in the Plan to the contrary, various class(es) and/or subclass(es) of Eligible Employees may be designated under the Plan for various purposes including, but not limited to, eligibility.

2.27 Employee

(a) Subject to paragraph (b) below, any individual who is classified as a common law employee by the Employer on a "full-time" basis," and is (or would be, but for an approved leave of absence) on the Employer's W-2 payroll. A person is employed on a full-time basis if he works an average of 30 or more hours per week on an annual basis.

(b) The term "Employee" shall not include:

(1) A part-time, casual, or on-call employee;

(2) Any leased employee (including but not limited to any individual defined as a "leased employee" in Section 414(n) of the Code) or individual classified by the Employer as an independent contractor or as self-employed, for the period during which the individual is so classified, whether or not such individual is determined by the IRS or others to be a common law employee of the Employer;

(3) Any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which the individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common law employee of the Employer;

(4) A person who is a member of a collective bargaining unit for which benefits under this Plan have not been provided pursuant to a collective bargaining agreement with an Employer; or

(5) A nonresident alien, except for a nonresident alien schedule to work on a full-time basis who has a visa that requires the Employer to provide coverage under the Plan, such as H1B, H1B1 or Trade NAFTA (but not F1, J1, or H2B). An individual working on a bull-time basis for an Employer who has an employment authorization card such as a "green card" shall also be an Employee.

2.28 Employer

The Company, each Affiliated Employer (if any) that has adopted (or may hereafter adopt) and adheres to the Plan in accordance with the provisions of Article X hereof, and any successor to the Company or an adopting Affiliated Employer.

2.29 ERISA

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

2.30 Excepted Benefit

An "excepted benefit" within the meaning of Section 9831(c) of the Code. For example, in accordance with 26 C.F.R. § 54.9831-1(c)(3)(v), the Health Flexible Spending Accounts are "excepted benefits" if other group health plan benefits (other than Excepted Benefits) are available in addition to the Health Flexible Spending Accounts, and the Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, benefit does not exceed two times the salary reduction or, if greater, the salary reduction plus $500.

2.31 Flexible Benefits Plan

The portion of this Plan set forth in Article VI, and including the Flexible Spending Accounts.

2.32 Flexible Spending Accounts

Collectively, the Health Flexible Spending Accounts and the Dependent Care Flexible Spending Account. The Flexible Spending Accounts are each a part of the Flexible Benefits Plan.

2.33 FMLA

The Family and Medical Leave Act of 1993, as amended from time to time.

2.34 Group Health Plan

An employee welfare benefit plan within the meaning of Section 3(1) of ERISA to the extent that such plan provides "medical care" within the meaning of Section 733(a) of ERISA.

2.35 Health Care Flexible Spending Account

The portion of this Plan set forth in Article VII, limited to the provisions described therein as being applicable to the Health Care Flexible Spending Account. The Health Care Flexible Spending Account is a part of the Flexible Benefits Plan. The Health Care Flexible Spending Account is also commonly known as the Health Care FSA.

2.36 Health Care Professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

2.37 Health Flexible Spending Accounts

Collectively, the Health Care Flexible Spending Account and the Limited Use Flexible Spending Account.

2.38 Health Savings Account or HSA

A "health savings account" within the meaning of Section 223(d) of the Code, to which contributions may be made pursuant to the Flexible Benefits Plan. Although:

(a) contributions to a Health Savings Account may from time to time be made by (or by the Employer on behalf of) a Participant in a High Deductible Health Plan under the Flexible Benefits Plan, and

(b) such Health Savings Accounts may be limited to those maintained with a qualified trustee or custodian designated by the Company,

any such Health Savings Account is separately established by the Participant and is not a part of this Plan, and is not intended to, and does not, constitute an ERISA plan, all within the contemplation of Department of Labor Field Assistance Bulletins 2004-01 and 2006-02 (and subsequent guidance).

2.39 High Deductible Health Plan or HDHP

A "high deductible health plan" within the meaning of Section 223(c)(2) of the Code that is offered under the Plan.

2.40 HIPAA

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

2.41 Independent Review Organization

An entity that conducts independent external reviews of Adverse Benefit Determinations and final internal Adverse Benefit Determinations pursuant to 29 C.F.R. § 2590.715-2719(c) or (d), as applicable.

2.42 Insurance Company or Insurer

An insurance company that is qualified to do business in a state (or other applicable jurisdiction) and that validly issues an Insurance Contract.

2.43 Insurance Contract

A group insurance contract or policy issued by an Insurance Company to provide certain benefits under the Plan to or with respect to applicable Covered Persons pursuant to Article V of the Plan.

2.44 IRS

The Internal Revenue Service.

2.45 Key Employee

An employee described in Section 416(i)(1) of the Code.

2.46 Limited Use Flexible Spending Account

The portion of the Plan set forth in Article VII, limited to the provisions described therein as being applicable to the Limited Use Flexible Spending Account. The Limited Use Flexible Spending Account is a part of the Flexible Benefits Plan. The Limited Use Flexible Spending Account is also commonly known as the Limited Use FSA.

2.47 Medicaid

Title XIX of the Social Security Act, as amended from time to time.

2.48 Medicare

Title XVIII of the Social Security Act, as amended from time to time.

2.49 Notice or Notification

The delivery or furnishing of information to an individual in the manner that satisfies the standards of 29 C.F.R. § 2520.104b-1(b) as appropriate with respect to material required to be furnished or made available to an individual.

2.50 Participant

An individual who is an Eligible Employee and who satisfies the eligibility requirements of Article III, and, if required, who properly elects to participate in the Plan. The term "Participant" also includes a former Eligible Employee whom the Company has agreed to allow to continue to participate in the Plan pursuant to a written severance agreement, to the extent of any benefits available thereto under the Plan.

2.51 Period of Coverage

With respect to any Plan Year, that Plan Year. However, for any Employee: (i) who becomes a Participant after the start of a Plan Year, the Period of Coverage means the period commencing on the Effective Date of the Participant's participation and extending through the remainder of the Plan Year; and/or (ii) who ceases being a Participant after the start of a Plan Year, the Period of Coverage means the period commencing on the first day of the Period of Coverage for that Plan Year and extending through the last day of the Participant's participation.

With respect to the Health Flexible Spending Accounts, the Period of Coverage shall include any period of COBRA continuation provided pursuant to Section 7.09.

2.52 PHS Act

The Public Health Service Act, as amended from time to time.

2.53 Plan

The Ryman Hospitality Properties Employee Health and Welfare Plan, as set forth herein (including in the appendices hereto) and as subsequently amended, together with any and all Coverage Documents and any and all amendments and supplements to any of such Coverage Documents.

2.54 Plan Administrator

The Benefits Trust Committee, or such person(s) or committee as may be appointed by the Company or its delegate to supervise and carry out the administration of the Plan. To the extent the Plan is subject to ERISA, the Plan Administrator shall be the "plan administrator" within the meaning of ERISA.

Notwithstanding the foregoing, certain powers and/or responsibilities may from time to time be delegated to another party (see, e.g., Sections 4.01(f) and 4.08); therefore, any reference in the Plan to the "Plan Administrator" shall mean *the Plan Administrator or its delegate*.

2.55 Plan Year

The 12 consecutive month period beginning on January 1 and ending on December 31. The Plan's fiscal record are kept on the basis of the Plan Year (although one or more Insurance Contracts may operate on a different policy year).

2.56 Post-Service Claim

Any claim for a benefit under a Group Health Plan that is not a Pre-Service Claim.

2.57 Pre-Service Claim

Any claim for a benefit under a Group Health Plan with respect to which the terms of the Plan condition receipt of the benefits, in whole or in part, on approval of the benefit in advance of the payment of medical care.

2.58 Provider Group Contract

A group service contract or agreement issued by a Provider Organization to provide certain health related benefits under the Plan to Covered Persons pursuant to Article V of the Plan.

2.59 Provider Organization

An accountable care organization (ACO), exclusive provider organization (EPO), health maintenance organization (HMO), preferred provider organization (PPO), or other similar provider or network organization, by whatever name called.

2.60 QMCSO

A "qualified medical child support order" as that term is defined in Section 609(a) of ERISA. The term "QMCSO" includes a "National Medical Support Notice" deemed to constitute a qualified medical child support order pursuant to Section 609(a)(5)(C) of ERISA.

2.61 Qualified Beneficiary

A "qualified beneficiary" within the meaning of Section 4980B(g)(1) of the Code. Generally, this means any individual who is, as of the day before a Qualifying Event, (i) an employee covered under health benefits offered under the Plan as of such day; (ii) the covered Spouse of the Participant; or (iii) a covered Dependent child of the Participant. An employee can be a Qualified Beneficiary only if the Qualifying Event consists of termination of employment (other than for gross misconduct) or a reduction of hours of the employee's employment. A child born or placed for adoption with an employee or former employee during COBRA continuation coverage will also be considered as a Qualified Beneficiary (to the extent required by law). A former employee actively participating in the Plan by reason of a previous period of employment may also be treated as a Qualified Beneficiary for purposes of the COBRA rules.

2.62 Qualifying Event

A "qualifying event" within the meaning of Section 4980B(f)(3) of the Code.

2.63 Qualifying Medical Care Expense

(a) In General for the Health Flexible Spending Accounts. An expense incurred by a Participant, or by the Dependent of such Participant, for "medical care" as defined in Section 213(d) of the Code and as supplemented from time to time as applicable to health flexible spending arrangements in Sections 105, 106, and 125 of the Code (including, without limitation, in Section 106(f)); provided, however, that such expense is reimbursable only to the extent that the Participant or other individual incurring the expense has not been reimbursed and, to the extent required by the Code, the Participant certifies that they will not seek reimbursement, for the expense through insurance or otherwise (other than under the Health Care Flexible Spending Account).

A Qualifying Medical Care Expense generally shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

(b) Limited Use Flexible Spending Account. Notwithstanding anything in subsection (a) to the contrary, for the purpose of the Limited Use Flexible Spending Account, the term "Qualifying Medical Care Expense" shall be limited to those Qualifying Medical Care Expenses (as defined in subsection (a) above) incurred for dental care and vision care within the contemplation of Proposed Department of the Treasury Regulations at 26 C.F.R § 1.125-5(m)(3), so as not to disqualify a Participant from also contributing to a Health Savings Account.

2.64 Relevant

A document, record, or other information shall be deemed by the Plan Administrator as "Relevant" to a claimant's claim if such document, record, or other information:

(a) was relied upon in making the benefit determination;

(b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(c) demonstrates compliance with administrative processes and safeguards required pursuant to 29 C.F.R. § 2560.503-1(b)(5) in making the benefit determination; or

(d) in case of a Group Health Plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

2.65 Rescission or Rescinded

A "rescission" as defined in 29 C.F.R. § 2590.715-2712(a)(2). Generally, this means a cancellation or discontinuance of medical coverage that has a retroactive effect, and does not include a cancellation or discontinuance of coverage that:

(a) has only a prospective effect;

(b) is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions (including COBRA premiums) toward the cost of coverage; or

(c) is initiated by the Covered Person (or the Covered Person's authorized representative), and the Employer or the Plan or the Insurer does not, directly or indirectly, take action to influence the Covered Person's decision to cancel or discontinue coverage retroactively or otherwise take any adverse action or retaliate against, interfere with, coerce, intimidate, or threaten the Covered Person.

Also, effective with respect to disability coverage, the term "Rescission" includes a cancellation or discontinuance of disability coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of disability coverage.

2.66 Restatement Effective Date

January 1, 2026, the effective date of this restatement of the Plan.

2.67 Reviewing Fiduciary

The person or organization responsible for administering claims that, depending on the coverage selected, may be the applicable Insurance Company that has issued the applicable Insurance Contract, the applicable Provider Organization that is party to the applicable Provider Group Contract (to the extent such Provider Group Contract so provides), the applicable Claims Administrator that is party to the Administrative Services Agreement (to the extent such Administrative Services Agreement so provides), the Company, the Plan Administrator, or other applicable person, committee, or organization to the extent such role is delegated thereto. To the extent the Company self-insures the benefits and coverages, in full or in part, under the Plan, the Plan Administrator or its duly authorized representative or agent shall be the Reviewing Fiduciary, except to the extent the Administrative Services Agreement, Provider Group Contract, or Coverage Document otherwise explicitly provides.

2.68 Salary Reduction Agreement

An agreement, or deemed agreement, between the Participant and the Employer under which the Participant and the Employer agree to reduce the Participant's Compensation and to have such amounts applied to cover the Participant's share of the cost of the Benefit Options they have elected under the Flexible Benefits Plan. To the extent required by Section 125 of the Code, the Salary Reduction Agreement shall only apply to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement in accordance with rules and policies established by the Plan Administrator.

2.69 Salary Reduction Amount

The amount of Compensation in any Period of Coverage elected, or deemed elected, by the Participant to be applied to the purchase of Benefit Options under the Flexible Benefits Plan pursuant to a Salary Reduction Agreement.

2.70 Spouse

An individual who is the Participant's "spouse" within the meaning of federal tax law.

2.71 USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

ARTICLE III.
ELIGIBILITY AND PARTICIPATION

3.01 Eligibility for and Commencement of Coverage.

(a) In General.

On and after the Restatement Effective Date, each Eligible Employee, including each Dependent of an Eligible Employee, or former Eligible Employee, as applicable, who satisfies the eligibility, enrollment, and premium requirements for coverage, under Section 3.02 and in the Coverage Documents and/or enrollment materials (as such requirements may be specified from time to time therein) shall become a Covered Person in this Plan on their Effective Date.

On and after the Restatement Effective Date, each Eligible Employee shall be eligible to participate in the Flexible Benefits Plan portion of this Plan on the Restatement Effective Date, or, if later, on the earliest date the Employee becomes eligible for coverage under a Benefit Option.

If, during any period, the Company has not regarded an individual as an Eligible Employee, then that individual shall not be eligible to participate in the Plan for that period, even in the event that the individual is determined, retroactively, by the IRS or otherwise, to have been an Employee or an Eligible Employee during all or a portion of that period.

(b) Exceptions to the General Rules Above.

(i) Notwithstanding anything in subsection (a) above or the Plan to the contrary:

1) the Plan Administrator may establish special eligibility and participation commencement date(s) and procedure(s) for individuals previously employed by an Affiliated Employer and who become Employees, for Employees of an Affiliated Employer at the time such Affiliated Employer first adopts the Plan, or for individuals employed by an Employer (or an employer) in connection with a corporate or other acquisition or transaction (whether asset or equity-based or otherwise); and

2) otherwise Eligible Employees who are covered by a collective bargaining agreement under which benefits of the type offered under this Plan have been subject to good faith negotiations are eligible to participate in the Plan to the extent provided in the applicable collective bargaining agreement.

(ii) Except as otherwise provided in a Coverage Document or in the applicable enrollment materials, an Eligible Employee's transfer of employment among the Employers shall not affect the Eligible Employee's status as a Participant.

3.02 Election to Participate.

An Eligible Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete enrollment in the form and manner prescribed by the Plan Administrator for the election of benefits available under this Plan. If an Eligible Employee fails to make an election (which may include an affirmative election against coverage, if required) during their initial Election Period, the Eligible Employee shall be deemed to have elected the default coverage(s) and Benefit Option(s) (if any) as designated by the Company from time to time in the enrollment materials.

With respect to the Benefit Options under the Plan, any election or deemed election made with respect to such enrollment shall be irrevocable during their Period of Coverage unless the Participant is entitled to change their election pursuant to Section 6.10.

3.03 Cessation of Participation.

A Covered Person shall cease to be a Covered Person as of the earliest of:

(a) The end of the month following termination date;

(b) the date on which the Covered Person is no longer eligible under the terms of the Plan (including any applicable Coverage Document(s));

(c) with respect to a Participant who is no longer able to make the required contributions under the Plan, the last day of the period for which the Participant made the required contributions;

(d) the date as of which the Covered Person's coverage is terminated pursuant to Section 13.20; or

(e) the last day of the Plan Year if the Participant elects, or is deemed to have elected, against coverage under the Plan for the next following Plan Year.

For this purpose, a transfer of employment between Employers will not be considered a termination of employment.

Notwithstanding the foregoing, the Plan Administrator may adopt uniform rules of general application regarding the continuation of participation, in whole or in part, under the Plan for Participants who are on temporary layoff or an approved leave of absence or who have transferred to an Affiliated Employer that is not an adopting Employer.

Notwithstanding anything in the Plan to the contrary, certain coverage(s) under the Plan that would otherwise end for a Participant by reason of the Participant's termination of employment shall continue for the period of time during which the individual receives, pursuant to a written severance agreement or otherwise, and subject to the terms of any applicable Insurance Contract(s), continuation of such coverage(s).

3.04 Reinstatement of Former Participant.

Except as otherwise specifically provided in a Coverage Document, an individual who formerly participated in the Plan may resume participation in the Plan in accordance with the following, as applicable, with respect to any Benefit Option(s):

(a) Eligibility Changes. A former Participant shall again become a Participant if and when they meet the eligibility requirements of Section 3.01 and the election requirements of Section 3.02 (as applicable), except as otherwise provided in subsection (b) below.

(b) Termination of Employment.

(i) In the event a Participant terminates service and resumes service with an Employer within a 30-day period during the same Plan Year, then such Employee shall again become a Participant on the first day such Employee resumes employment with the Employer (as long as the Employee is otherwise an Eligible Employee) and the Participant's prior elections (or deemed elections pursuant to Section 3.02) with respect to the Benefit Options shall be automatically reinstated.

(ii) In the event a Participant terminates service and resumes service with an Employer after a 30-day period, but during the same Plan Year, then such Employee shall again become a Participant on the date the Employee again meets the eligibility requirements of Section 3.01 and the election requirements of Section 3.02.

(iii) In the event a Participant terminates service in one Plan Year and resumes service in the next Plan Year, then such Employee shall again become a Participant on the date the Employee again meets the eligibility requirements of Section 3.01 and the election requirements of Section 3.02.

3.05 Leaves of Absence.

(a) Family and Medical Leave Act of 1993.

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the FMLA, to the extent required by the FMLA, the Plan Administrator will continue to maintain the Participant's group health plan coverage(s) under this Plan (including the Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable) on the same terms and conditions as though they were still an active Employee. In

such cases, the Participant shall have the right to continue their elected group health plan coverage(s) during such leave or to terminate such coverage(s).

If the Participant opts to continue their group health plan coverages during such qualifying unpaid leave, then the Participant may pay their required contributions in one of the following ways, *as determined by the Employer in accordance with its FMLA leave policy*:

(i) Pay-as-you-go with after-tax dollars, by sending monthly payments to the Plan Administrator or on a pre-tax basis to the extent the contributions are made from taxable Compensation (e.g., from unused sick days or vacations days) that is due the Employee during the leave.

(ii) Pre-pay with pre-tax dollars, by pre-paying all or a portion of the contribution for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave Compensation or on a pre-tax basis to the extent the contributions are made from taxable Compensation (e.g., from unused sick days or vacation days) that is due the Employee during the leave. To pre-pay the contribution, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year). In addition, contributions may also be made on an after-tax basis under this option.

(iii) Catch-up the contributions due under an arrangement agreed upon between the Participant and the Employer (e.g., the Employer may fund coverage during the leave and withhold "catch-up" amounts upon the Participant's return).

Upon return from such leave, the Participant will be permitted to re-enter the Plan on the same basis as the Participant was participating in the Plan prior to their leave, or as otherwise required by the FMLA.

However, for the Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, if the coverage terminates due to revocation of the benefit or due to nonpayment of contributions by the Participant, two options will be offered for such benefit upon the Participant's return to work:

(i) Proration. The Participant may elect to resume coverage at a reduced level without making payment of any unpaid contributions. In this case, the Participant's maximum contribution amount will be reduced proportionately for the time that the Participant was not paying premiums. Expenses incurred by the Participant during the lapse in coverage period are not reimbursable.

(ii) Reinstatement. The Participant may elect to reinstate the level of coverage in effect when the leave began, with unpaid contribution amounts being made up for the remainder of the Plan Year. The maximum coverage level originally elected will remain in effect for the Plan Year, but the Participant cannot submit claims for reimbursement that were incurred during the lapse in coverage period.

If a Participant goes on a qualifying paid leave under the FMLA, the Participant will continue coverage under the Plan while on FMLA leave by the method normally used during any paid leave. In all instances, a paid or unpaid leave under the FMLA will be treated in the same manner and consistent with, respectively, a non-FMLA paid or unpaid leave.

Notwithstanding anything in the Plan to the contrary, this Plan shall be operated in accordance with the requirements of the FMLA (including any amendments thereto), the provisions of which are hereby incorporated by reference, and the Plan Administrator has full power and discretion to cause the Plan to be so operated, including without limitation, the power to interpret, construe, and implement all applicable provisions of FMLA and the provisions of 26 C.F.R. § 1.125-3, in such manner as the Plan Administrator deems appropriate and consistent with the provisions of the Plan.

(b) Other Leaves of Absence.

If a Participant goes on an approved leave other than a leave as set forth in subsection (a), the Participant may continue coverage under the Plan in accordance with (and subject to all terms of) the Employer's applicable leave policy or practice, applicable law, and/or the applicable Coverage Documents.

3.06 Compliance with Special Enrollment Requirements.

To the extent applicable, the Plan shall comply with the special enrollment requirements of HIPAA and CHIPRA, as such are codified at Section 9801(f) of the Code.

3.07 Qualified Medical Child Support Orders.

The Plan Administrator shall comply with the applicable terms of any QMCSO. The Plan Administrator shall establish procedures for: (a) notifying Participants and alternate recipients who have or may have an interest in benefits that are the subject of a medical child support order; (b) determining whether any such medical child support order constitutes a QMCSO under Section 609(a) of ERISA (i.e., determining the "qualified" status of any such order); and (c) administering the provision of benefits under any such QMCSO. The Plan Administrator shall document such procedures in writing and shall make such written procedures available to Participants and beneficiaries on request and without charge.

3.08 Proof of Dependent Eligibility.

The Plan Administrator may request and require satisfactory proof of Dependent status at any time and from time to time as a condition of the Covered Person receiving or continuing coverage under the Plan.

3.09 Death.

If a Participant dies, the Participant's participation in the Plan shall cease. However, such Participant's beneficiaries, or representatives of the Participant's estate, may submit claims for benefits or expenses incurred prior to the Participant's death, which such claims shall be administered in accordance with (and subject to all requirements of) the terms of the Plan.

ARTICLE IV.
ADMINISTRATION OF PLAN

4.01 Powers, Duties, and Responsibilities of the Plan Administrator.

The Plan Administrator shall be the "named fiduciary" under the Plan and shall be responsible for controlling and managing the operation and administration of the Plan; provided, however, that to the extent benefits provided under the Plan are insured, then the terms and conditions of coverage of the Insurance Contract, as identified as a Coverage Document in Appendix A, shall control, and as such, the Insurance Company shall be the "named fiduciary" and claims administrator responsible for administering and controlling such Coverage Documents, with the applicable power and discretion afforded the Plan Administrator as described below.

The Plan Administrator shall have the full and absolute power and discretion to control the operation and administration of this Plan, with all powers necessary to enable it to properly carry out such responsibilities, including, but not limited to, the power to construe the terms of this Plan; to determine status, coverage, and eligibility for benefits; and to resolve all interpretive, equitable, and other questions that may arise in the operation and administration of the Plan.

For this purpose, the Plan Administrator's powers will include, but will not be limited to, the following authority, in addition to other powers provided by this Plan:

(a) to make and enforce such rules and regulations and prescribe the use of such forms as it deems necessary, desirable, and/or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;

(b) to interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan, and legally binding on all parties;

(c) to decide all questions concerning the Plan and the eligibility of any person to participate in the Plan, and to establish procedures with respect thereto;

(d) to require any person to furnish such information as it may request or require for the purpose of the proper or efficient administration of the Plan (including, but not limited to, the information required for the Plan Administrator and/or the Employer to comply with (i) the secondary payer reporting requirements of Medicare and (ii) the Affordable Care Act) as a condition to receiving any benefits under the Plan;

(e) to engage such agents, legal counsel, actuaries, accountants, consultants, experts, specialists, advisers, and other persons as may be required to assist in administering the Plan;

(f) to allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation, or designation to be in writing (which such writing may be, but need not be, made in this Plan or in a Coverage Document); and

(g) notwithstanding anything herein to the contrary, to require or allow electronic or telephonic (or any other form of) submission of any and all documentation required under the Plan, including without limitation, enrollment forms, Salary Reduction Agreements, and claim forms.

4.02 Records and Reports.

The Plan Administrator shall keep a record of actions taken and shall keep other books of account, records, and other data that may be necessary for proper administration of the Plan and shall be responsible for supplying information and reports to governmental agencies or departments, employees, Participants, beneficiaries, Covered Persons, and/or others as required by law.

The fiscal records of the Plan shall be maintained on the basis of the Plan Year, provided, however, that the policy year of any Insurance Contract may be different from the Plan Year.

4.03 Reliance on Tables, Etc.

In administering the Plan, the Plan Administrator shall be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by, or in accordance with the instructions of, the Insurance Company, the Provider Organization, the Claims Administrator, or by legal counsel, accountants, actuaries, consultants, experts, specialists, advisers, or other persons employed or engaged by the Plan Administrator.

4.04 Nondiscriminatory Exercise of Authority.

Whenever, in the administration of the Plan, any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise its authority in a nondiscriminatory manner so that persons similarly situated will receive substantially the same treatment.

4.05 Fiduciary Liability.

One fiduciary shall not be liable or responsible for the acts of commission or omission of another fiduciary unless:

(a) the fiduciary knowingly participated in or knowingly undertook to conceal the act or omission of another fiduciary;

(b) the fiduciary knew the act or omission was a breach of fiduciary responsibility by the other fiduciary and failed to make reasonable efforts to remedy the breach; or

(c) the fiduciary's breach of their own fiduciary responsibilities enabled the other fiduciary to commit a breach.

4.06 Indemnification of Plan Administrator.

The Employer(s) agree to indemnify and to defend to the fullest extent permitted by law any employee who serves as the Plan Administrator or as its delegate (including any employee or former employee of an Employer who formerly served as the Plan Administrator or as its delegate) against all liabilities, damages, costs, and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Plan Administrator) occasioned by any act or omission to act in connection with the Plan, if such act or omission is the result of good faith. This indemnification shall be limited to the costs and expenses not reimbursed under any fiduciary insurance provided by the Employer(s). Any indemnification payments made by reason of this section shall not be made from any assets of the Plan.

4.07 Expenses of Administration.

All expenses incurred that arise in connection with the administration of the Plan, including, but not limited to, administrative expenses, compensation, and other expenses, and charges of any legal counsel, accountants, actuaries, consultants, experts, specialists, advisers, or other persons employed or engaged by the Plan Administrator in connection with the administration of the Plan, shall be paid by the Employer(s); provided, however, that, with respect to the Flexible Spending Accounts, any reasonable expenses incurred in administering the Flexible Spending Accounts may be paid first from forfeitures to the extent provided in Section 7.06 (with respect to the Health Flexible Spending Accounts) and Section 8.06 (with respect to the Dependent Care Flexible Spending Account), and then by the Employer(s).

4.08 Allocation of Responsibilities.

The Company may from time to time make further allocations of fiduciary responsibility among one or more "named fiduciaries." With the approval of (or authority conveyed by) the Company, its Board, or its delegate, the Plan Administrator may designate in writing persons other than named fiduciaries to carry out fiduciary responsibilities under the Plan.

In the event a committee is designated to carry out certain fiduciary responsibilities under the Plan, each member of the committee shall be prohibited from voting or participating in any matter relating solely to their individual rights or benefits under the Plan, and each member shall be covered by the indemnification provisions of Section 4.06. Decisions and actions of such committee may be by majority vote at a meeting or by writing signed by all members of the committee without the necessity of a

meeting, except as otherwise may be set forth from time to time in such committee's formal governance document(s) (e.g., in a committee charter).

4.09 Bonding

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

ARTICLE V.
CONTRIBUTIONS, INSURANCE, AND SOURCE OF BENEFITS

5.01 Participant Contributions.

As a condition to coverage under the Plan, a Participant shall make such contributions as necessary to satisfy the applicable premium, if any, specified for such coverage under the Coverage Documents or required by the Company and communicated in enrollment materials. The Company shall establish (and the Plan Administrator shall communicate to Participants) the applicable premium rates for each type of coverage under the Coverage Documents and the deadlines and procedures for making such premium payments.

5.02 Insurance Contracts and Provider Group Contracts.

The Company (or its delegate), in its absolute discretion, may purchase insurance to provide coverage and benefits, in full or in part, under the Plan. Similarly, the Company, in its absolute discretion, may enter into one or more Provider Group Contracts with one or more Provider Organizations to provide coverage and benefits, in full or in part, under the Plan.

5.03 Source of Benefits.

(a) Except as provided in subsection (b) below, the conditions of coverage, benefits, manner and time of payment, and other provisions regarding the welfare benefits hereunder are set forth in the Coverage Documents and by this reference, such Coverage Documents are made a part hereof.

(b) The conditions of coverage, benefits, manner and time of payment, and other provisions regarding the Flexible Benefits Plan, Health Flexible Spending Accounts, and Dependent Care Flexible Spending Account are as set forth in Articles VI, VII, and VIII, respectively.

(c) To the extent the Employer self-insures the benefits and coverages, in full or in part, under the Plan, benefits payable on behalf of the Participants that are self-insured by the Employer shall be paid from the general assets of the Employer and/or from Participants' contributions as specified in Section 5.01 above, in the applicable Coverage Documents, and in the Flexible Benefits Plan (as applicable).

(d) To the extent coverage and benefits under the Plan are provided through an Insurance Contract or, if applicable, Provider Group Contract, all associated premiums shall be paid to such Insurer or Provider Organization from the general assets of the Employer and Participants' contributions (as specified in Section 5.01 above, in the applicable Coverage Documents, and/or in the enrollment materials, and in the Flexible Benefits Plan, as applicable).

(e) The terms and conditions for coverage and benefits are as set forth in such Insurance Contracts and/or Provider Group Contracts, which are Coverage Documents, and the Participants shall look solely and exclusively to such Insurance Contracts and/or Provider Group Contracts for the payment of all claims and/or the provision of coverage thereunder. The terms and conditions of coverage and benefits as set forth in the Coverage Documents, which constitute Insurance Contracts and Provider Group Contracts, will determine whether a claim for benefits under such Coverage Documents will be granted or denied. Neither the Plan Administrator, the Company, nor any other Employer has the authority to make, influence or alter the determinations made by the Insurer or Provider Organization that issued such contract(s), in regard to claims for benefits under such contract(s) (except as otherwise provided in the applicable Coverage Document).

5.04 Subrogation and Reimbursement.

The rights of the Plan as described in this Section 5.04 are, with respect to any particular coverage under the Plan, in addition to any rights described in the applicable Coverage Document, and shall apply to the extent not inconsistent with the terms of such Coverage Document.

To the extent that benefits are provided for a Covered Person, the Plan is entitled to certain subrogation and reimbursement rights. The Covered Person must:

(a) reimburse the Plan for any benefits provided on behalf of the Covered Person when any such benefits are recovered in any form, from any person, insurer, other entity, contract, or fund, including without limitation any payment made as a result of the requirements under a "no fault" motor vehicle insurance statute or other similar legislation, and regardless of whether any settlement, judgment, or other award specifically designates the recovery, or any portion thereof, as including medical or health expenses; and/or

(b) subrogate the Plan to any and all claims, causes of actions, or rights that may arise against any person, corporation, or other entity who have or may have caused, contributed to, or aggravated the injury or condition for which the Covered Person claims an entitlement to benefit under the Plan, and to any claims, causes of action, or rights that the Covered Person may have against or under any person, insurance policy, contract, or fund.

This entitlement to subrogation, and to full reimbursement and recovery, may not be reduced on account of the recovery being less than the actual loss suffered by the Covered Person. The Covered Person must assist the Plan by providing any information and executing any documents as are reasonable and necessary to protect the Plan's interest and enforce the Plan's rights. Failure to cooperate will entitle the Plan Administrator to refuse payment of any claims for benefits under the Plan, and to recover from the Covered Person any and all benefits provided, and for the cost and attorneys' fees incurred in collecting these amounts.

In all cases, the Plan shall have a first lien against any recovery the Covered Person receives, and the right to institute, or intervene in, any lawsuit, claim, or proceeding to protect the Plan's interest, including the right to sue, compromise, or settle in the Covered Person's name, a legal action for recovery of the benefits provided. The Plan's first lien rights will not be reduced due to the Covered Person's own negligence, or due to the Covered Person not being made whole, or due to attorneys' fees and costs.

If the Covered Person fails to timely and fully reimburse the Plan for the benefits provided on behalf of the Covered Person as described above, then any future benefits payable on behalf of the Covered Person (or any covered family member of the Covered Person) under the Plan may be offset by any amounts owed by the Covered Person to the Plan.

The Plan Administrator is granted the right and authority to pursue and enforce (and, as it may determine in its sole discretion is necessary or appropriate, to negotiate) the provisions of this Section 5.04, including without limitation, the right, power, and standing to institute all appropriate legal action in its own name or in the name of the Plan.

The conditions set forth in this Section 5.04 shall not diminish, waive, or foreclose any common law, statutory, or equitable right that the Plan may have under applicable law, and all such rights in the interest of the Plan and each Covered Person under the Plan hereby are expressly reserved to such persons.

The Covered Person shall have no authority to sign a release to any third party, insurance company, contract, or fund for monies for which the Plan may be entitled to reimbursement under this Section 5.04, and no benefits shall be payable under this Plan for any charges or expenses, for any injury, illness or other condition for which a Covered Person has already received a recovery from such third party, insurance company, contract, or fund.

5.05 Coordination of Benefits.

The Plan shall coordinate benefits when a Covered Person is eligible for benefits under this Plan and one or more other plan(s). The specific coordination of benefits provisions are set forth in the applicable Coverage Document(s).

5.06 Non-Assignability of Benefits and Other Rights and Obligations.

(a) Non-Assignability of Benefits. Except as expressly provided in the Plan (including, with respect to a particular coverage, in the applicable Coverage Document), benefits available or provided under the Plan:

(i) are not in any way subject to debts or other obligations of a Participant (or other Covered Person or a beneficiary) entitled thereto;

(ii) may not be voluntarily or involuntarily sold, transferred, alienated, assigned, or encumbered; and

(iii) shall not be subject to being taken by their creditors by any process whatsoever; and

any attempt to cause such benefits to be so subjected will not be recognized, except to the extent required by law (e.g., as required by the tax withholding provisions of applicable law).

(b) Non-Assignability of Other Rights and Obligations. Except as expressly provided in the Plan (including, with respect to a particular coverage, in the applicable Coverage Document), any other rights and/or obligations under the Plan to or with respect to a Participant (or other Covered Person or a beneficiary) may not be voluntarily or involuntarily sold, transferred, alienated, assigned, or encumbered, and any attempt to cause such right or obligation to be so subjected will not be recognized except to the extent required by law (e.g., by the designation of an authorized representative pursuant to Section 11.01(c)).

5.07 Treatment of Insurance Policy or Other Distributions Received by the Company.

If and to the extent the Company, as the policyholder of any Insurance Contract or Provider Group Contract or otherwise for which it pays all or a portion of the applicable premiums, becomes entitled to receive a distribution from the Insurer (for example, a rebate pursuant to Section 2718 of the PHS Act; i.e., the medical loss ratio provisions of the Affordable Care Act) or Provider Group Organization or otherwise, then such payment distributed shall be allocated consistent with applicable fiduciary obligations under ERISA. For example:

(a) the Plan Administrator may calculate the applicable portion, if any, of such distribution proceeds as is attributable to Participant contributions (and/or other Plan assets) based on a reasonable allocation method as the Plan Administration shall determine in its discretion; and

(b) the Plan Administrator may determine in its discretion how to use that portion attributable to Participant contributions (if any) for the benefit of applicable Participants, which may include (but not be limited to) applying the rebate toward future Participant premiums or toward future benefit enhancements; provided, however, that such proceeds shall be applied as soon as practicable after such amounts are received by the Company and within any time period prescribed by law, as directed by the Plan Administrator; and

(c) except as specifically determined by the Plan Administrator in its discretion pursuant to subsection (a) above, no portion of such distribution will constitute or be deemed to constitute Plan assets.

ARTICLE VI.
FLEXIBLE BENEFITS PLAN

6.01 Separate Written Plan.

This Article VI, along with all other relevant portions of the Plan, is intended to serve as the separate written plan of the Flexible Benefits Plan for purposes of Section 125 of the Code. The Flexible Benefits Plan is a part of the Plan.

The capitalized words, terms, and phrases used in this Article VI shall have the same meanings as those defined in Article II of the Plan.

All Participants in the Flexible Benefits Plan (including in the Flexible Spending Accounts) must be "employees" within the meaning of Section 125 of the Code.

6.02 Benefit Options.

Each Participant may elect under this portion of the Plan, by Salary Reduction Agreement, to receive their full Compensation in cash or to have a portion of their Compensation for a Plan Year applied by their Employer toward the purchase (cost) of one or more of the Benefit Options. In the event a Participant is deemed to have elected the default Benefit Option(s) pursuant to Section 3.02 (if any), such Participant shall also be deemed to have entered into a Salary Reduction Agreement with respect to such Benefit Options.

6.03 Description of Benefits Other than Cash.

(a) In General. While the election to receive one or more of the Benefit Options may be made under the Flexible Benefits Plan, the benefits will not be provided by this Flexible Benefits Plan but by the Benefit Option(s) elected. The types of benefits and amounts available under each such Benefit Option, the requirements for participation, and the other terms and conditions of eligibility, coverage, and benefits are as set forth from time to time in the applicable Coverage Document; and, with respect to the Health Flexible Spending Accounts, in Article VII; and, with respect to the Dependent Care Flexible Spending Account, in Article VIII. As further described in Section 6.14, and notwithstanding anything in this Flexible Benefits Plan or a Benefit Option to the contrary, in no event shall this Plan be construed to offer a benefit that defers compensation.

(b) Employer Contributions (if any) to Health Savings Accounts under the Flexible Benefits Plan. Furthermore, pursuant to this Flexible Benefits Plan, the Employer may make contributions to the Health Savings Accounts of Participants who are enrolled in a High Deductible Health Plan in such amounts and at such time(s) as the Company may determine in its discretion, and such amounts shall be communicated to Participants in the Coverage Document(s) applicable to such High Deductible Health Plan(s) and/or in enrollment materials.

6.04 Funding the Cost of Benefit Options/Salary Reduction Agreements.

Each Eligible Employee desiring one or more Benefit Options under Section 6.02 must enter into a Salary Reduction Agreement (or deemed Salary Reduction Agreement) for a Plan Year and apply such amount to the purchase of the Benefit Options elected. The amount of the reduction in Compensation for a Plan Year shall be equal to the Participant's share of the cost of the Benefit Options they elect, or are deemed to have elected. The balance of the cost of such elected Benefit Options, if any, shall be paid by the Participant's Employer with non-elective employer contributions.

The amount of a Participant's Compensation that they elect (or are deemed to have elected) to reduce and apply to the purchase of Benefit Options (the Salary Reduction Amount) shall be deducted from the Participant's Compensation on a pro rata basis to be determined by the number of pay periods remaining during the Plan Year for which the election applies (except as otherwise specifically provided in the Plan and/or permitted by law). Such election shall be evidenced by a Salary Reduction Agreement in such form and manner as deemed acceptable to the Plan Administrator (except in cases whereby the Participant is deemed to have entered into a Salary Reduction Agreement pursuant to Section 6.02). The Salary

Reduction Amount shall be adjusted automatically in the event of a change in the cost of Benefit Options, except as otherwise provided in Section 6.10.

6.05 Election Procedures.

This paragraph shall apply except to the extent Section 6.08 applies. During the Election Period for each Plan Year, the Plan Administrator shall provide the opportunity for enrollment (which shall include the Salary Reduction Agreement), which may be in written, electronic, telephonic, or other form or manner prescribed by the Plan Administrator (hereinafter referred to as an "election form"), to each Participant and to each other Eligible Employee who is expected to become a Participant at the beginning of the Plan Year. Each Participant who desires coverage under one or more of the Benefit Options for the Plan Year shall so specify on an election form during the appropriate enrollment period and shall agree to a reduction in their Compensation as provided in Section 6.04. Each election form must be completed and provided to the Plan Administrator on or before such date as the Plan Administrator shall specify, which date shall be no later than the first day of the Plan Year for which the Participant's election applies.

A Participant's elections on the Salary Reduction Agreement may automatically terminate or may be terminated or modified by action of the Plan Administrator in accordance with Section 6.10(c) or 6.13 herein.

All Benefit Option elections under the Plan (or deemed elections pursuant to Sections 6.02 and 6.09) shall be irrevocable by the Participant during the Plan Year for which the election applies, except as otherwise provided in Section 6.10.

6.06 Other Limitations on Benefits Provided

(a) Health Flexible Spending Accounts. A Participant may elect to receive payments or reimbursements of Qualifying Medical Care Expenses incurred in any Plan Year up to any dollar amount specified by the Participant, but not less than the minimum (if any) and not in excess of the maximum amounts that may be allocated to the Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, as stated on the election form and/or in the enrollment materials for the Plan Year (which minimum and maximum amounts shall be set in advance of the Plan Year by the Company and/or the Plan Administrator). For this purpose, amounts received that are attributable to reimbursements due the Participant's Spouse or other Dependent(s) shall be considered to have been received by the Participant.

Notwithstanding anything in the Plan to the contrary, the maximum amount that may be allocated to the Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable for a Plan Year pursuant to a Salary Reduction Agreement shall be subject to any applicable maximum as may be required by the Affordable Care Act or other applicable law.

All expenses incurred are subject to the proof of loss and other provisions of Article VII.

(b) Dependent Care Flexible Spending Account. A Participant may elect to receive payments or reimbursements of Dependent Care Expenses incurred in any Plan Year up to any dollar amount specified by the Participant, but not less than the minimum (if any) and not in excess of the maximum amounts that may be allocated to the Dependent Care Flexible Spending Account as stated on the election form and/or in the enrollment materials for the Plan Year (which minimum and maximum amounts shall be set in advance of the Plan Year by the Company and/or the Plan Administrator), subject to the limitation described below.

The maximum amount that the Participant may elect to receive in the form of Dependent Care Flexible Spending Account reimbursements under this Plan shall be limited to the lesser of:

(i) the Participant's earned income for the Plan Year (after all reductions in Compensation including the reduction related to the Dependent Care Flexible Spending Account);

(ii) the actual or deemed earned income of the Participant's Spouse for the Plan Year; or

(iii) $5,000, if the Participant is either unmarried or will file a joint federal income tax return for the year; otherwise, $2,500.

In the case of a Spouse who is a full-time student at an educational institution or is physically or mentally incapable of self-care, such Spouse shall be deemed to have earned income of not less than $250 per month if the Participant has one Dependent and $500 per month if the Participant has two or more Dependents. In the case of two Participants who are married to each other and who file a joint federal income tax return for the calendar year, the $5,000 limit in (iii) above shall be reduced for each such Participant by the amount received for the year under this Plan by the Participant's Spouse. For purposes of this subsection (b), "earned income" shall have the meaning given it by Section 32(c)(2) of the Code, and marital status shall be determined under the special rules of Sections 21(e)(3) and (4) of the Code.

All expenses incurred are subject to the proof of loss and other provisions of Article VIII.

(c) Contributions to a Health Savings Account. A Participant's Salary Reduction Amount for contributions to their Health Savings Account for the Plan Year shall be limited to the minimum and maximum amounts that may be so allocated as stated on the election form or in the enrollment materials, subject to the applicable limitation prescribed by Section 223(b)(2) of the Code. For 2026, these limitations are: (i) for an individual with self-only HDHP coverage, $4,400, and (ii) for an individual with family HDHP coverage, $8,750. Furthermore, an additional catch-up contribution for the Plan Year as permitted by Section 223(b)(3) of the Code (currently, $1,000) may also be made by a Participant who is age 55 or older.

The applicable limitation shall be reduced by the amount of contributions made, if any, by the Employer to the Participant's Health Savings Account on the Participant's behalf (other than by Salary Reduction Agreement) pursuant to Section 6.03(b) of this Flexible Benefits Plan.

6.07 Maximum Contributions.

Unless otherwise specified herein, the maximum Salary Reduction Amount under the Plan for any Participant shall be the sum of the costs of the most expensive Benefit Options available to the Participant under this Plan, as modified from time to time, and subject to the maximum elections permitted for the Flexible Spending Accounts under Sections 6.06(a) and (b) and for a Health Savings Account under Section 6.06(c).

6.08 New Participants.

The Plan Administrator shall provide the opportunity for enrollment described in Section 6.05 to each person who becomes an Eligible Employee as soon as reasonably practicable following such Employee's first date of employment with an Employer or classification as an Eligible Employee eligible to participate in the Plan. If the Eligible Employee desires coverage in one or more of the Benefit Options under this Plan (other than the default Benefit Options, if any, pursuant to Section 3.02), including the Flexible Spending Accounts, if applicable, for the remainder of the Plan Year, the Eligible Employee shall so specify in an appropriate "election form" (within the meaning set forth in Section 6.05) and shall agree to a reduction in their Compensation as provided in Section 6.04. Each election form must be completed and provided to the Plan Administrator on or before such date as the Plan Administrator shall specify, which date shall be no later than the first day of the first pay period for which the election is applicable (except as otherwise permitted by law).

6.09 Deemed Election.

(a) Initial Plan Year. A Participant who fails to complete and provide their election form to the Plan Administrator on or before the specified due date for the initial Plan Year in which they became a Participant, shall be deemed to have elected only the default Benefit Options (if any) pursuant to Section 3.02. The Participant shall also be deemed to have agreed to a reduction in their Compensation for the Plan Year in an amount equal to the Participant's share of the cost of the Benefit Options they are deemed to have elected (if any) for the Plan Year.

(b) Subsequent Plan Years. Except as otherwise determined by the Company and communicated to Participants in the enrollment materials with respect to a particular Plan Year, for subsequent Plan Years, a Participant who fails to notify the Plan Administrator on or before the specified due date

for any Plan Year shall be deemed to have made the elections as were in effect at the end of the preceding Plan Year. The Participant shall also be deemed to have agreed to a reduction in their Compensation for the subsequent Plan Year in an amount equal to the Participant's share of the cost of the Benefit Options they are deemed to have elected, if any, for such Plan Year. Notwithstanding the foregoing, as to the Flexible Spending Accounts and contributions to a Health Savings Account, in the absence of an election to participate for the subsequent Plan Year, the Participant shall be deemed to have elected cash Compensation in lieu of such Benefit Options, regardless of any election in effect during the preceding Plan Year.

6.10 Change of Elections.

(a) General Rule (Irrevocability). Elections made for Benefit Options under the Plan (or deemed made under Section 3.02 or 6.09) shall be irrevocable by the Participant during a Period of Coverage, except as otherwise provided in this Section 6.10.

(b) Exceptions to the General Rule—Events Permitting Exceptions to the Irrevocability Rule. A Participant generally may revoke a Benefit Option election for the balance of a Period of Coverage and make a new election if both the revocation and new election are consistent with the terms of this Plan (including this Section 6.10) and/or the Benefit Option(s) at issue. Any revocation and new election required to be made by the Participant must be made by notice to the Plan Administrator at such time and in such manner as prescribed by the Plan Administrator (but not less than 30 days—or such longer period as may be required by law; e.g., 60 days in the event of a Medicaid- or CHIP-related special enrollment event as described at Section 9801(f)(3) of the Code—of the event forming the basis for the requested change), and will be effective only at such time as the Plan Administrator shall determine is administratively feasible or is required by law, subject to the terms of the applicable Coverage Document(s).

Notwithstanding anything in the Plan to the contrary, each of the following shall be interpreted consistent with 26 C.F.R. § 1.125-4 and other applicable guidance under Section 125 of the Code.

(i) *Special Enrollment Rights*. A Participant may change an election for group health plan coverage under the Plan that is not an Excepted Benefit during a Period of Coverage and make a new election that corresponds with the special enrollment rights provided in HIPAA and CHIPRA as set forth in Section 9801(f) of the Code (and in Section 3.06 of the Plan).

(ii) *Change in Status Events*. Any Participant may change a Benefit Option election and make a new election if, under the facts and circumstances, the changes are on account of and consistent with a Change in Status Event. Whether a change in election is consistent with the Change in Status Event shall be interpreted in accordance with 26 C.F.R. § 1.125-4(c)(3).

(iii) *Judgment, Decree, or Order*. In the event of a judgment, decree, or order ("Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) that requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant:

1) The Plan may change an election to provide applicable coverage for the child if the Order requires coverage under the Plan; or

2) The Participant shall be permitted to change an election to cancel applicable coverage for the child if the Order requires the spouse, former spouse, or other individual to provide coverage for such child and that coverage is, in fact, provided.

(iv) *Entitlement to (or Loss of Eligibility for) Medicare or Medicaid*. A Participant may change elections and cancel accident or health plan coverage under the Plan for the Participant or the Participant's Dependent (including a Spouse) to the extent the Participant or the Participant's Dependent becomes entitled to coverage (i.e., becomes

enrolled) under Part A or Part B of Medicare or under Medicaid, other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). In addition, if the Participant or any eligible Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may file a new election for the balance of the Period of Coverage to commence or increase coverage under a Benefit Option that constitutes accident or health coverage.

(v) *Changes in Cost*. The following shall in no event apply to election changes with respect to the Health Flexible Spending Accounts (or on account of any changes in cost or coverage under the Health Flexible Spending Accounts).

1) Automatic Changes for Insignificant Cost Changes. If, during the Period of Coverage, the cost of a Benefit Option increases (or decreases) insignificantly, as determined by the Plan Administrator in its sole discretion, and the terms of the Plan require Participants to make corresponding changes in their contributions, then the Plan Administrator may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in affected Participants' elective contributions for the Benefit Option.

2) Significant Cost Increase. If, during the Period of Coverage, the cost of a Benefit Option increases significantly, as determined by the Plan Administrator in its sole discretion, then each affected Participant may: (A) make a corresponding prospective increase to their Salary Reduction Agreement; (B) revoke their election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another benefit package option offered under the Plan that provides similar coverage; or (C) drop coverage prospectively if there is no other Benefit Option available that provides similar coverage.

3) Significant Cost Decrease. If, during a Period of Coverage, the cost of a Benefit Option significantly decreases, as determined by the Plan Administrator in its sole discretion, then: (A) Participants who are enrolled in a Benefit Option other than the Benefit Option that has decreased in cost may change their election on a prospective basis to elect the Benefit Option that has decreased in cost; and (B) Participants who are otherwise eligible may elect the Benefit Option that has decreased in cost on a prospective basis, subject to the terms and conditions of such Benefit Option.

This subsection (v) applies to the Dependent Care Flexible Spending Account only if the cost change is imposed by a Dependent Care Service Provider who is not a relative of the Participant. For this purpose, a "relative" is an individual who is related as described in Sections 152(d)(2)(A) through (G), incorporating the rules of Sections 152(f)(1) and 152(f)(4), of the Code.

(vi) *Changes in Coverage*. The following shall in no event apply to election changes with respect to the Health Flexible Spending Accounts (or on account of any changes in cost or coverage under the Health Flexible Spending Accounts).

1) Significant Coverage Curtailment. If the coverage under a Benefit Option (or if the coverage of a Dependent, including a Spouse) is significantly curtailed (within the meaning of 26 C.F.R. § 1.125-4(f)(3)(i)) or there is a loss of coverage (within the meaning of 26 C.F.R. § 1.125-4(f)(3)(ii)) during a Period of Coverage, each affected Participant may revoke their election of a Benefit Option coverage and, in lieu thereof, elect to receive on a prospective basis coverage under another option with similar coverage offered under the Plan, or in the event of a loss of coverage, drop such coverage if there is no similar coverage available under the Plan. For purposes of the Dependent Care Flexible Spending Account,

a Participant's change in Dependent Care Service Provider shall be treated as a change in available coverage.

2) Addition or Improvement of a Benefit Package Option. If, during the Period of Coverage, a new Benefit Option or other coverage option is added to the Plan or an existing Benefit Option is significantly improved, then each affected Participant may elect the newly-added option or significantly improved coverage prospectively and make corresponding election changes with respect to other Benefit Options providing similar coverage.

3) Change in Coverage under Another Employer Plan. In the event a Participant or the Participant's Dependent (including a Spouse) makes an election change under an employer plan (including a plan of the Employer or a plan maintained by the Dependent's employer), the Plan Administrator may permit the Participant to revoke an election under this Plan and make a new election for the balance of the Period of Coverage that is on account of and corresponds with the election change made by the Participant or the Participant's Dependent, if: (A) the election change made under the other plan is permitted under Section 125 of the Code (e.g., under 26 C.F.R. §§ 1.125-4(b) through (g), disregarding (f)(4)); or (B) the period of coverage under the other plan does not correspond with the Period of Coverage of this Plan.

4) Loss of Coverage under Other Group Health Coverage. If the Participant or the Participant's Dependent (including a Spouse) loses coverage under any group health coverage sponsored by governmental or educational institution, the Participant may elect for the balance of the Period of Coverage to commence coverage under a Benefit Option on a prospective basis, subject to the terms and conditions of such Benefit Option. Such other group health coverage may include, but is not limited to (A) CHIP coverage, (B) a medical care program of an Indian Tribal government, (C) a state health benefits risk pool, or (D) a foreign government group health plan.

(vii) *Special Requirements Relating to the FMLA*. A Participant who is taking leave under the FMLA may revoke an existing election of accident or health plan coverage and make such other election for the remaining portion of the Period of Coverage as may be provided for under or with respect to the FMLA, including under 26 C.F.R. § 1.125-3.

(viii) *Special Rule Applicable to Health Savings Account Contributions*. Notwithstanding anything in this Section 6.10 or the Plan to the contrary, a Participant who is enrolled in a High Deductible Health Plan may revoke or change their election to contribute to a Health Savings Account at any time, subject to the applicable limitation(s) described in Section 6.06(c) for the Plan Year. Any revocation and new election must be made by notice to the Plan Administrator at such time and in such manner as prescribed by the Plan Administrator, and will be effective prospectively, and only at such time as the Plan Administrator shall determine is administratively feasible.

(c) Exceptions to the General Rule—Modification by the Plan Administrator.

(i) *Compliance with Nondiscrimination Requirements and Limitations on Benefits Provided*. In the event the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement under the Code (including as described in Section 6.13) or any limitation on the amount of benefits that can be provided to a class of Employees, the Plan Administrator shall take action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification, reduction, or cancellation of elections by a Participant (or class of Participants) with or without the consent of any such Participant(s).

(ii) *Mistaken Election*. In the event the Plan Administrator determines in its sole discretion, before or during any Plan Year, that there is clear and convincing evidence of a mistake with regard to a Flexible Spending Account or other Flexible Benefits Plan election, the Plan Administrator may take such action as the Plan Administrator deems appropriate (and determined to be permitted under Section 125 of the Code), under rules uniformly applicable to similarly situated Participants, to cause such mistake to be corrected.

6.11 Transfers of Employment.

Upon the transfer of a Participant between Employers, a Participant's elections with respect to the Benefit Options shall remain in effect and shall not be modified or revoked, except as otherwise provided in the Plan and/or in the applicable enrollment materials. Such a Participant's election shall automatically be adjusted to reflect any change in the cost of their coverage under the Benefit Options as determined by the Plan Administrator (subject to Section 6.10 of the Plan).

6.12 Automatic Termination of Election(s).

Elections made under this Plan shall automatically terminate on the date of payment to the Participant of compensation for the pay period ending immediately after (a) the date of the Participant's termination of employment with the Employer, or (b) the date of termination of the Participant's status as an Eligible Employee. Notwithstanding the termination of the election, coverage or benefits under this Plan or the Benefit Options may continue if and to the extent provided by the Plan or such Benefit Options, or by operation of law.

6.13 Nondiscrimination.

This Section 6.13 shall be interpreted in accordance with the applicable provisions of the Code.

In accordance with Sections 125(b)(1) and (2) of the Code, the Plan shall not discriminate in favor of "highly compensated participants" (as defined in Section 125(e)(1) of the Code) as to contributions and benefits, or in favor of "highly compensated individuals" (as defined in Section 125(e)(2) of the Code) as to eligibility to participate, nor shall the Plan fail to satisfy any nondiscrimination or other requirement applicable to Key Employees or other "highly compensated employees" (as defined in Section 414(q) of the Code). In this regard, the Plan shall not provide more than 25% of qualified benefits to Key Employees.

If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code, or any limitation on benefits provided to Key Employees, highly compensated participants, or other highly compensated individuals, the Plan Administrator shall take such action as it deems necessary and appropriate, under rules uniformly applicable to similarly situated employees, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by Key Employees, highly compensated individuals, or highly compensated employees, or a reduction in such individuals' non-taxable benefit under this Plan, with or without their consent.

The Plan Administrator may designate one or more cafeteria plans under the Plan for nondiscrimination testing purposes and may aggregate or disaggregate any such plans for testing purposes to any extent the Plan Administrator determines is permissible under applicable law.

6.14 Prohibition against Deferred Compensation.

The Participant may not reduce their Compensation if or to the extent such reduction results in the deferral of compensation beyond the end of the Plan Year for which such election applies. This requirement shall be interpreted in accordance with Section 125 of the Code, including (to the extent it remains applicable) Proposed Department of the Treasury Regulations ("Proposed Treasury Regulations") at 26 C.F.R. § 1.125-1(o).

6.15 Taxability of Salary Reduction Amount.

A Participant's Compensation shall be reduced by the Salary Reduction Amount before calculation of any applicable federal, state, and local taxes, unless otherwise required by the Code or applicable state or local law.

ARTICLE VII.
HEALTH FLEXIBLE SPENDING ACCOUNTS

7.01 Separate Written Plan.

This Article VII, along with all other relevant portions of the Plan, is intended to serve as the separate written plans of the Health Flexible Spending Accounts for purposes of 26 C.F.R. § 1.105-11(b)(1)(i) and Section 125 of the Code. The capitalized words, terms, and phrases used in this Article VII shall have the same meanings as those defined in Article II or in the Flexible Benefits Plan.

7.02 Health Flexible Spending Accounts.

The Plan Administrator will establish and maintain on its books a Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, for each Plan Year with respect to each Participant who has elected to receive reimbursement of Qualifying Medical Care Expenses incurred during their Period of Coverage, as applicable.

For a Participant enrolled in a High Deductible Health Plan, only the Limited Use Flexible Spending Account is available.

7.03 Credit to Health Flexible Spending Accounts.

There shall be credited to a Participant's Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, for each Plan Year, as of each date Compensation is paid to the Participant in such Plan Year, an amount equal to the reduction, if any, to be made in such Compensation in accordance with such amount as is designated in the Participant's election form. To the extent required by applicable law, the entire amount of annual coverage specified in the Participant's election form for that Plan Year shall be credited to their Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, as of the first day of the Participant's Period of Coverage (referred to as the "uniform coverage" rule). All amounts credited to each such Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, shall be the property of the Employer until paid out pursuant to Section 7.04 (or used as provided in Section 7.06).

7.04 Debit of Health Flexible Spending Accounts.

A Participant's Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, for each Plan Year shall be debited from time to time in the amount of any payment under Section 7.08 to or for the benefit of the Participant for Qualifying Medical Care Expenses incurred during their Period of Coverage. Amounts debited to each such Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, shall be treated as payments of the earliest amounts credited to the account and not yet treated as paid under this sentence, under a "first-in/first-out" approach.

Notwithstanding the foregoing, the Plan Administrator may make available a debit card (within the meaning of Proposed Treasury Regulations at 26 C.F.R. § 1.125-6) to enable an eligible Participant to pay for Qualifying Medical Care Expenses. In addition to the requirements generally applicable to the Health Flexible Spending Accounts, the use of debit cards will be subject to the requirements of Proposed Treasury Regulations at 26 C.F.R. § 1.125-6 and other applicable IRS guidance. The Plan Administrator is authorized to adopt, from time to time, such administrative procedures and requirements as may reasonably be deemed necessary or appropriate to facilitate the debit card program under the Health Flexible Spending Accounts, provided such procedures are not inconsistent with the terms of the Flexible Benefits Plan and applicable law. All such procedures and requirements shall be communicated to Participants and are hereby incorporated into, and will be deemed to be an integral part of, the Plan.

7.05 Reimbursements from and Balance of Health Flexible Spending Accounts; Carryovers.

(a) In General. The amount credited to a Participant's Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, for any Plan Year shall be used only to reimburse the Participant for Qualifying Medical Care Expenses incurred during their Period of Coverage and only if the Participant applies for reimbursement on or before the March 31

immediately following the close of the Plan Year. Upon such reimbursement, the Employer, the Plan, and the Plan Administrator shall be relieved of all future responsibility with respect to the expenses reimbursed.

Except as specifically provided in subsection (b) below, if any balance remains in the Participant's Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, with respect to any Plan Year after all reimbursements are made hereunder, such balance shall not be carried over to reimburse the Participant for Qualifying Medical Care Expenses incurred during or with respect to a subsequent Plan Year, and shall not be available to the Participant in any other form or manner, but shall remain the property of the Employer (subject to Section 7.06), and the Participant shall forfeit all rights with respect to such balance.

(b) Carryovers Permitted under the Health Flexible Spending Accounts.

(i) *In General*. Notwithstanding anything in the Health Flexible Spending Accounts (including in subsection (a) above) or the Flexible Benefits Plan to the contrary, if any balance remains in the Participant's Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, with respect to a Plan Year after all reimbursements hereunder, the amount set forth in subsection (ii), below, shall be carried over to reimburse the Participant for Qualifying Medical Care Expenses incurred during the subsequent Plan Year. The carried-over balance shall not count against the subsequent Plan Year's Salary Reduction Amount limit described in Section 6.06(a). The following additional conditions shall apply to such carryovers:

1) Carryovers may not be cashed out or converted to any other taxable or nontaxable benefit.

2) For a carryover from a Health Care Flexible Spending Account for a Participant who, for the next Plan Year, enrolls in a High Deductible Health Plan that is paired with a Health Savings Account, the carryover balance will be converted to a Limited Use Flexible Spending Account.

(ii) *Maximum Carryover Amount*. The maximum amount that may be carried over from any Plan Year to reimburse the Participant for Qualifying Medical Care Expenses incurred during the subsequent Plan Year shall be set in advance of the Plan Year by the Company or the Plan Administrator, and shall be communicated to Participants in the enrollment materials for the Plan Year. Notwithstanding the preceding sentence or anything in the Plan to the contrary, such maximum with respect to any Plan Year shall in no event exceed twenty percent (20%) of the maximum salary reduction contribution permitted under Section 125(i) of the Code for that Plan Year, as determined in accordance with Internal Revenue Service Notice 2020-33 and other applicable guidance.

7.06 Forfeitures.

Except as provided in 7.05(b) above, amounts remaining in a Health Care Flexible Spending Account or Limited Use Flexible Spending Account shall be forfeited after payment of all timely presented claims for such reimbursement for expenses incurred during the applicable Period of Coverage or as permitted under Section 13.10. Such forfeitures may be used for any purpose permitted by law (including to cover shortages resulting from the application of the "uniform coverage" rule, as provided in Section 7.03; and for the payment of expenses of administering the Health Flexible Spending Accounts, as provided in Section 4.07), as determined by the Company.

7.07 Termination of Participation.

In the event that a Participant ceases to be a Participant in this Plan for any reason, the Participant's Salary Reduction Agreement relating to the Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, shall terminate. The Participant shall be entitled to reimbursement only for Qualifying Medical Care Expenses incurred on or prior to the date of termination of participation within the same Plan Year, and only if the Participant (or the Participant's authorized

representative pursuant to Section 11.01(c)) applies for such reimbursement in accordance with Section 7.08. No such reimbursement shall exceed the remaining balance, if any, in the Participant's Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, for the Plan Year in which the expenses were incurred.

In the event of the Participant's death, the Participant's Spouse (or, if none, the Participant's executor or administrator) or an authorized representative may apply on the Participant's behalf for reimbursement permitted under this Section 7.07.

7.08 Application, Claim, and Review Procedures.

(a) Application for Health Care Flexible Spending Account or Limited Use Flexible Spending Account Benefits. A Participant who has elected to participate in the Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, for a Plan Year may apply to the Claims Administrator for reimbursement of Qualifying Medical Care Expenses incurred by the Participant during their Period of Coverage, by submitting a request for reimbursement on a form or in the manner prescribed by the Plan Administrator, along with documentation of the expenses, as further explained below, to the Claims Administrator. The Participant must submit the completed requests and any required documentation to the Claims Administrator at the address shown on the form by the due date set forth in Section 7.05. If the request qualifies as an expense eligible to be paid under the Plan, the Participant will receive a reimbursement payment soon thereafter.

Such application must be accompanied by a written statement from an independent third party, stating that the expense has been incurred and the amount of the expense, and by such other bills, invoices, receipts, canceled checks, or other statements or certifications showing the amounts of such expenses, together with any additional documentation that the Claims Administrator or Plan Administrator may request. An explanation of benefits (EOB) indicating the date of the service and the amount the Participant is responsible to pay may be substituted for the third party statement and documentation described in the preceding sentence. The Plan Administrator may establish a minimum reimbursement amount.

(b) Reimbursement for Qualifying Medical Care Expenses. The Participant shall be reimbursed from their Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, for Qualifying Medical Care Expenses incurred during their Period of Coverage for which the Participant submits documentation in accordance with subsection (a). No reimbursement under this subsection (b) of expenses incurred shall be required if the Participant's claim, except for the final claim associated with a Plan Year, is for an amount less than the minimum reimbursable amount established by the Plan Administrator, if any. The amount of any Qualifying Medical Care Expenses not reimbursed as a result of the preceding sentence shall be carried over and reimbursed if and when the minimum reimbursable amount is met or, if earlier, after the end of the Plan Year for which the expense relates.

(c) Claims Procedures. The Plan Administrator shall establish reasonable procedures concerning the filing of claims for benefits hereunder, and shall administer such procedures uniformly. With respect to the Health Flexible Spending Accounts, the Plan Administrator shall have full and complete discretion to make all determinations as to the eligibility of any person.

When required, claims for benefits must be filed with the Plan Administrator on forms or in the manner prescribed by the Plan Administrator. All claims for benefits under the Health Flexible Spending Accounts must be filed with the Claims Administrator within the period described in Section 7.05.

In accordance with subsection (a), the Plan provides benefits under the Health Flexible Spending Accounts solely on a Post-Service Claim basis. In the case of any claims for benefits under the Health Flexible Spending Accounts, the claim and review procedures of Article XI that are applicable to Post-Service Claims under a Group Health Plan shall apply. The Health Flexible

Spending Accounts provide for one mandatory level of appeal of an Adverse Benefit Determination.

7.09 Continuation of Coverage.

If a Participant terminates employment with the Employer (or otherwise loses eligibility under the Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable) due to a Qualifying Event, the Participant and/or other Qualified Beneficiary(ies) may be able to elect to continue their participation in the Plan with respect to the Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, pursuant to COBRA as set forth in this Section 7.09:

(a) COBRA continuation coverage will not be offered to Qualified Beneficiary(ies) in the Health Flexible Spending Accounts if both of the following apply:

(i) The Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, has a deficit at the time of the Qualifying Event (i.e., if, taking into account all claims submitted on or before the date of the Qualifying Event, the Qualified Beneficiary's remaining Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, balance for the Plan Year is less than the maximum required COBRA premiums for the rest of the Plan Year); and

(ii) The Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, is an Excepted Benefit.

(b) The Qualified Beneficiary(ies) may elect to continue participation in the Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, for the remainder of the Plan Year in which the Qualifying Event occurs only if:

(i) The Health Care Flexible Spending Account or Limited Use Flexible Spending Account is an Excepted Benefit; and

(ii) The maximum amount the Qualified Beneficiary could be required to pay for the remainder of the Plan Year is less than the maximum benefit available to the Qualified Beneficiary for the Plan Year.

(c) If the Health Care Flexible Spending Account or Limited Use Flexible Spending Account is an Excepted Benefit, the Qualified Beneficiary's ability to continue coverage under the Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, shall cease as of the end of the Plan Year in which the Qualifying Event occurs.

(d) If the Health Care Flexible Spending Account or Limited Use Flexible Spending Account is an Excepted Benefit, the Qualified Beneficiary(ies) shall have the ability to continue coverage under the Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, under procedures and conditions set forth below.

The Plan Administrator will notify Qualified Beneficiary(ies) in the Health Flexible Spending Accounts as to their COBRA eligibility (if any).

If a Qualified Beneficiary elects to continue participation in their Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, for the remainder of the Plan Year in which such termination occurs, the Qualified Beneficiary may continue to seek reimbursement from the Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable. The Qualified Beneficiary shall be required to make contributions to the account based on the elections in effect on the day before the Qualifying Event, plus an additional 2% of such elected amount to cover the costs of processing and administering their COBRA election.

If a Participant and/or other Qualified Beneficiary does not elect to continue participation in the Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, for the remainder of the Plan Year in which such termination occurs, the Participant's participation in the Plan shall cease and no further contributions shall be made. However, such Participant may submit claims for expenses incurred during the portion of their Period of Coverage preceding their date of termination

provided the claims are submitted within the time period otherwise required by the Plan (see Section 7.05(a)). In the event a Participant terminates their participation in the Health Care Flexible Spending Account or Limited Use Flexible Spending Account, as applicable, during the Plan Year, if contributions are made other than on a pro rata basis, upon termination the Participant shall be entitled to a reimbursement for any contributions previously paid for coverage or benefits relating to the period after the date of the Participant's separation from service regardless of the Participant's claims or reimbursements as of such date.

ARTICLE VIII.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

8.01 Separate Written Plan.

This Article VIII, along with all other relevant portions of the Plan, is intended to serve as the separate written plan of the Dependent Care Flexible Spending Account for purposes of Section 129(d)(1) of the Code. The capitalized words, terms, and phrases used in this Article VIII shall have the same meaning as those defined in Article II or in the Flexible Benefits Plan.

8.02 Dependent Care Flexible Spending Account.

The Plan Administrator will establish and maintain on its books a Dependent Care Flexible Spending Account for each Plan Year with respect to each Participant who has elected to receive reimbursement of Dependent Care Expenses incurred during the period beginning on the first day of their Period of Coverage and ending on the last day of the Plan Year.

8.03 Credit to Dependent Care Flexible Spending Account.

There shall be credited to a Participant's Dependent Care Flexible Spending Account for each Plan Year, as of each date Compensation is paid to the Participant in such Plan Year, an amount equal to the Salary Reduction Amount, if any, to be made from such Compensation in accordance with such amount as is designated in the Participant's election form. All amounts credited to each such Dependent Care Flexible Spending Account under this Section 8.03 shall be the property of the Employer until paid out pursuant to Section 8.04 (or used as provided in Section 8.06).

8.04 Debit of Dependent Care Flexible Spending Account.

A Participant's Dependent Care Flexible Spending Account for each Plan Year shall be debited from time to time in the amount of any payment under Section 8.08 to or for the benefit of the Participant for Dependent Care Expenses incurred during the period beginning on the first day of their Period of Coverage and ending on the last day of the Plan Year. Amounts debited to each such Dependent Care Flexible Spending Account shall be treated as payments of the earliest amounts credited to the account and not yet treated as paid under this sentence, under a "first-in/first-out" approach.

Notwithstanding the foregoing, the Plan Administrator may make available a debit card (within the meaning of Proposed Treasury Regulations at 26 C.F.R. § 1.125-6) to enable an eligible Participant to pay for Dependent Care Expenses. In addition to the requirements generally applicable to the Dependent Care Flexible Spending Account, the use of debit cards will be subject to the requirements of Proposed Treasury Regulations at 26 C.F.R. § 1.125-6 and other applicable IRS guidance. The Plan Administrator is authorized to adopt, from time to time, such administrative procedures and requirements as may reasonably be deemed necessary or appropriate to facilitate the debit card program under the Dependent Care Flexible Spending Account, provided such procedures are not inconsistent with the terms of the Flexible Benefits Plan and applicable law. All such procedures and requirements shall be communicated to Participants and are hereby fully incorporated into, and will be deemed to be an integral part of, the Plan.

8.05 Reimbursements from and Balance of Dependent Care Flexible Spending Account.

The amount credited to a Participant's Dependent Care Flexible Spending Account for any Plan Year shall be used only to reimburse the Participant for Dependent Care Expenses incurred during the period beginning on the first day of their Period of Coverage and ending on the last day of the Plan Year, and only if the Participant applies for reimbursement on or before the March 31 immediately following the close of the Plan Year. Upon such reimbursement, the Employer, the Plan, and the Plan Administrator shall be relieved of all future responsibilities with respect to the expenses reimbursed.

If any balance remains in the Participant's Dependent Care Flexible Spending Account with respect to any Plan Year after all reimbursements are made hereunder, such balance shall not be carried over to reimburse the Participant for Dependent Care Expenses incurred during or with respect to a subsequent Plan Year, and shall not be available to the Participant in any other form or manner, but shall remain the

property of the Employer (subject to Section 8.06) and the Participant shall forfeit all rights with respect to such balance.

8.06 Forfeitures.

Amounts remaining in a Dependent Care Flexible Spending Account shall be forfeited after payment of all timely presented claims for such reimbursement for expenses incurred during the applicable period beginning on the first day of the Participant's Period of Coverage and ending on the last day of the Plan Year or as permitted under Section 13.10. Such forfeitures may be used for any purpose permitted by law (including for the payment of expenses of administering the Dependent Care Flexible Spending Account, as provided in Section 4.07), as determined by the Company.

8.07 Termination of Participation.

In the event that a Participant ceases to be a Participant in this Plan for any reason, the Participant's Salary Reduction Agreement relating to the Dependent Care Flexible Spending Account shall terminate. The Participant shall be entitled to reimbursement for Dependent Care Expenses incurred during the period beginning on the first day of the Participant's Period of Coverage and ending on the last day of the Plan Year, and only if the Participant (or the Participant's authorized representative) applies for such reimbursement in accordance with Section 8.08 and by the applicable date set forth in Section 8.05, or such later date as may be acceptable to the Plan Administrator if reasonable grounds exist for the delay. No such reimbursement shall exceed the remaining balance, if any, in the Participant's Dependent Care Flexible Spending Account for the Plan Year in which the expenses were incurred.

In the event of the Participant's death, the Participant's Spouse (or, if none, the Participant's executor or administrator) or an authorized representative may apply on the Participant's behalf for reimbursement permitted under this Section 8.07.

8.08 Application, Claim, and Review Procedures.

(a) Application for Reimbursement of Dependent Care Expenses. A Participant who has elected to participate in the Dependent Care Flexible Spending Account for a Plan Year may apply to the Claims Administrator for reimbursement of Dependent Care Expenses incurred by the Participant during the period beginning on the first day of their Period of Coverage and ending on the last day of the Plan Year, by submitting a request for reimbursement (on a form or in a manner prescribed by the Plan Administrator) along with documentation of the expenses, as further explained below, to the Claims Administrator. The Participant must submit the completed requests and any required documentation to the Claims Administrator at the address shown on the form. If the request qualifies as an expense eligible to be paid under the Plan, the Participant will receive a reimbursement payment soon thereafter. However, the Participant will only be reimbursed from their Dependent Care Flexible Spending Account to the extent that there are sufficient funds in such Participant's account to cover the request for reimbursement.

Such application must be accompanied by such bills, invoices, receipts, canceled checks, or other statements or certifications showing the amounts of such expenses, together with any additional documentation that the Claims Administrator or Plan Administrator may request. The Plan Administrator may establish a minimum reimbursement amount.

(b) Reimbursement of Dependent Care Expenses. The Participant shall be reimbursed from their Dependent Care Flexible Spending Account for Dependent Care Expenses incurred during the period beginning on the first day of the Participant's Period of Coverage and ending on the last day of the Plan Year, for which the Participant submits documentation in accordance with subsection (a). No reimbursement under this subsection (b) of expenses incurred shall at any time exceed the balance of the Participant's Dependent Care Flexible Spending Account for the Plan Year at the time of the reimbursement, nor shall any reimbursement or payment be required if the Participant's claim, except for the final claim associated with a Plan Year, is for an amount less than the minimum reimbursable amount established by the Plan Administrator, if any. The amount of any Dependent Care Expenses not reimbursed as a result of the preceding sentence

shall be carried over and reimbursed if and when the balance of such account permits such reimbursement, or if earlier, after the end of the Plan Year for which the expense relates.

(c) Claims Procedures. The Plan Administrator shall establish reasonable procedures concerning the filing of claims for benefits hereunder and appeals from denials of claims and shall administer such procedures uniformly. With respect to the Dependent Care Flexible Spending Account, the Plan Administrator shall have full and complete discretion to make all determinations as to the eligibility of any person.

Claims for benefits must be filed with the Claims Administrator on forms or in the manner prescribed by the Plan Administrator. All claims for Dependent Care Flexible Spending Account benefits must be filed with the Claims Administrator within the period described in Section 8.05.

8.09 Statement to Participants.

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

ARTICLE IX.
AMENDMENT AND TERMINATION OF PLAN

9.01 Amendment of Plan.

The Company (or the Plan Administrator to the extent such authority is delegated to it by the Human Resources Committee of the Board or its delegate) reserves the right at any time, and from time to time, without prior notice to or the consent of any Participant or any other person, to modify, alter, or amend the Plan, in whole or in part, effective as of a specified date. Any amendment to the Plan shall be documented in writing. No amendment shall have the effect of denying to any Participant a claim for benefits that has been incurred prior to or on such amendment date or denying benefits properly payable under the Plan for events that occurred prior to or on such amendment date (unless such amendment is made to comply with applicable law). Notwithstanding the foregoing, Appendices A through C may be replaced, in whole or in part, at any time by the Plan Administrator or a designated representative without the need to otherwise formally amend the Plan.

The Coverage Documents hereunder may be amended at any time, which shall be in accordance with the respective terms or procedures as set forth therein, as applicable.

Notwithstanding anything to the contrary herein, nothing contained herein is intended to, nor shall be construed to, require the Company to institute or continue in effect any particular plan or benefit sponsored by the Company, and the Company hereby reserves the right to amend or terminate any of the benefit programs at any time, in accordance with the procedures set forth therein, and without the prior notice to or consent of any Participant, Insurance Company, Provider Organization, Claims Administrator, Employer, or any other person, organization, or entity (except as required by law).

9.02 Retroactive Amendment.

Subject to the foregoing limitations, any amendment may be made retroactively that, in the judgment of the Company or its delegate, is necessary or advisable provided that such retroactive amendment does not deprive a Participant, without their consent, of a right to receive benefits that have already vested in such Participant, except such modification or amendment as shall be necessary to comply with any applicable law.

9.03 Termination of Plan.

The establishment and maintenance of the Plan and the payment or provision of any benefits hereunder are not, and are not to be construed as, contractual obligations. The Company, through action of its Board or its delegate, shall have the right to terminate the Plan, in whole or in part, at any time, including termination or cancellation of any or all Coverage Document(s) hereunder, effective as of such date as the Board or such delegate may determine in accordance with the procedures set forth in the Plan or Coverage Document (if applicable). However, no such termination shall have the effect of denying to any Participant a claim for benefits that properly has been incurred under the Plan prior to or on such termination date or denying benefits properly payable for events that occurred prior to or on such termination date.

9.04 No Vested Right to Benefits.

Notwithstanding anything in this Plan, including in any Coverage Document, to the contrary, no Employee or other individual shall have any vested right to continued benefits under the Plan and any benefits or coverage may be altered or terminated at any time for periods after the effective date of amendment or termination of the Plan pursuant to this Article IX.

9.05 Successor Plan.

Nothing in this Article IX shall restrict the right of the Company or its delegate to consolidate or replace this Plan with a comparable plan for the benefit of eligible Employees.

ARTICLE X.
ADOPTION OF PLAN BY AFFILIATED EMPLOYERS

10.01 In General.

Unless prohibited by the Company, its Board, or its delegate, the Plan may be adopted by any Affiliated Employer. Any such adoption shall be accomplished and evidenced in a manner satisfactory to the Company or its delegate, but it shall not be necessary for the Affiliated Employer to execute this document or any amendment hereto. The Affiliated Employers (if any) that have adopted this Plan are set forth from time to time in Appendix C.

From and after the effective date of such adoption, the adopting Employer shall assume all the rights, obligations, and liabilities of an Employer as described in the Plan. Each eligible Employee who is employed in that capacity by the Affiliated Employer immediately prior to the effective date of such adoption shall be eligible to participate in the Plan on the effective date of such adoption, except as otherwise provided in a Coverage Document and/or in the applicable enrollment materials (see, e.g., Section 3.01(b)(i)).

10.02 Withdrawal.

Any Employer shall have the right to withdraw its adoption of and adherence to the Plan by advance written notice to the Plan Administrator. An Employer shall not be eligible to continue its adoption of and participation in the Plan in the event such entity ceases to be an Affiliated Employer, effective as of such date as determined by the Company, its Board, or its delegate.

10.03 No Limitation of Powers.

The participation in the Plan by any Employer shall not limit the power of the Company or the Plan Administrator as set forth in this Plan. Amendments by the Company shall be binding upon all Employers. Acceptance by each such Employer shall be presumed. An Employer shall have no power to modify the provisions of the Plan in any respect, except each Employer has the right to withdraw from the Plan in accordance with Section 10.02. Withdrawal from the Plan by an Employer shall not affect the continued operation of the Plan with respect to the other Employers.

ARTICLE XI.
CLAIM AND REVIEW PROCEDURES

11.01 Claims Procedures.

(a) In General. The Plan Administrator, the applicable Insurance Company that has issued the applicable Insurance Contract, the applicable Provider Organization that is party to the applicable Provider Group Contract, or the applicable Claims Administrator that is party to the applicable Administrative Services Agreement (each hereinafter referred to in this Article XI as the "Organization"), shall establish reasonable procedures concerning the filing of claims for benefits, for appealing an Adverse Benefit Determination, and providing a full and fair review of the claim and Adverse Benefit Determination, and shall administer such procedures consistently with respect to similarly situated claimants (collectively, the "claims procedures"). The claims procedures as set forth in the Coverage Documents (or in Article VII with respect to the Health Flexible Spending Accounts, or pursuant to Article VIII with respect to the Dependent Care Flexible Spending Account) with respect to the benefits provided under such Coverage Documents (or in Article VII or pursuant to Article VIII, as applicable) shall control all claims for such benefits. Such claims procedures shall be interpreted in a manner consistent with the provisions of this Article XI and 29 C.F.R. § 2560.503-1, to the extent applicable.

(b) Compliance with the Affordable Care Act, the Consolidated Appropriations Act, 2021, and Other Applicable Law. Notwithstanding anything in this Article XI or the Coverage Documents to the contrary, to the extent applicable to the Plan and the applicable coverage(s) hereunder, the claims procedures shall include any internal claims and appeals procedures and any external review procedures as may be required from time to time by (i) the Affordable Care Act and any regulations (including at 29 C.F.R. § 2590.715-2719) and other guidance issued from time to time thereunder (collectively, the "Affordable Care Act guidance"); (ii) the Consolidated Appropriations Act, 2021; and/or (iii) other applicable law, the provisions of which are hereby incorporated by reference regardless of whether such provisions are specifically addressed herein.

(c) Designation of an Authorized Representative. An "authorized representative" of a claimant may act on behalf of the claimant in pursuing a benefit claim or appeal of an Adverse Benefit Determination, as required by 29 C.F.R. § 2560.503-1(b)(4), provided that the Plan Administrator may establish reasonable procedures for determining whether an individual has been so authorized to act on behalf of the claimant, and provided further that, in the case of a Claim Involving Urgent Care, a Health Care Professional with knowledge of the claimant's medical condition shall be permitted to act as the claimant's authorized representative with respect to that claim. To the extent required by law (including the Affordable Care Act guidance), references to "claimant" in this Article XI include a claimant's authorized representative.

11.02 Timing for Filing a Benefit Claim.

When required under the terms of this Plan and the Coverage Documents, claims for benefits may be filed with the applicable Organization on forms supplied (and/or by method(s) prescribed) by the Organization by the deadline for filing such a claim for benefits as set forth in the applicable Coverage Document (or in Article VII or pursuant to Article VIII, as applicable), or to the extent a Coverage Document is silent on this issue, within six (6) months after the date the services were originally performed. Unless otherwise provided in a Coverage Document (or in Article VII or pursuant to Article VIII, as applicable), if the Participant is unable to meet the deadline for filing such claim for reasons beyond the Participant's reasonable control, the Participant's claims will still be accepted if filed within 30 days of the date that the circumstances causing the delay of the claim are removed but not later than the end of the calendar year following the year in which the claim was originally incurred. Any claim filed outside of the applicable time limit will be denied and there will be no right to such benefit under the Plan.

11.03 Timing of a Notification of Benefit Determination.

Except as otherwise provided in Section 11.04 or 11.05 below, if a claim is wholly or partially denied, the Organization shall notify the claimant, in accordance with Section 11.07, of the Adverse Benefit

Determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Organization, unless the Organization determines that special circumstances require an extension of time for processing the claim. If the Organization determines that an extension of time for processing is required, written Notice of the extension shall be furnished to the claimant prior to the termination of the initial 90 day period. In no event shall such extension exceed a period of 90 days from the end of the initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the Organization expects to render a benefit determination.

11.04 Group Health Plan Claims.

Notwithstanding anything herein to the contrary, the following procedures shall apply to any claim for benefits under a Group Health Plan.

(a) Urgent Care Claims. In the case of a Claim Involving Urgent Care, the Organization shall notify the claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Organization, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Organization shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Organization, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with the Notice requirements set forth in Section 11.07. The Organization shall notify the claimant of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

(i) The Organization's receipt of the specified information, or

(ii) The end of the period afforded the claimant to provide the specified additional information.

(b) Concurrent Care Decisions. If an ongoing course of treatment to be provided over a period of time or number of treatments has been approved, the following procedures shall apply:

(i) Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Organization shall notify the claimant, in accordance with the Notice requirements set forth in Section 11.07, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

(ii) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a Claim Involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies, and the Organization shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Organization, provided that any such claim is made to the Organization at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving Urgent Care or not, shall be made in accordance with the Notice requirements set forth in Section 11.07, and appeal shall be governed by Section 11.08.

(c) Pre-Service Claims. In the case of a Pre-Service Claim, the Organization shall notify the claimant of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Organization. This period may be extended one time by the Organization for up to 15 days, provided that the Organization determines that such an extension is necessary due to matters beyond the control of the Organization and notifies the claimant, prior to the expiration of the

initial 15-day period, of the circumstances requiring the extension of time and the date by which the Organization 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. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with the Notice requirements set forth in Section 11.07.

Notwithstanding the above, in the case of a failure by a claimant or an authorized representative of a claimant to follow the Plan's procedures for filing a Pre-Service Claim, the claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This Notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a Claim Involving Urgent Care) following the failure. Notification may be oral, unless written Notification is requested by the claimant or authorized representative. This paragraph shall apply only in the case of a failure that:

(i) is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(ii) is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

(d) Post-Service Claims. In the case of a Post-Service Claim, the Organization shall notify the claimant, in accordance with the Notice requirements set forth in Section 11.07, of the 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 Organization for up to 15 days, provided that the Organization determines that such an extension is necessary due to matters beyond the control of the Organization 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 Organization 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.

11.05 Disability Claims.

In the case of a claim for disability benefits, the Organization shall notify the claimant, in accordance with Section 11.07, of the Adverse Benefit Determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Organization. This period may be extended by the Organization for up to 30 days, provided that the Organization both determines that such extension is necessary due to matters beyond the control of the Organization and notifies the claimant, prior to the expiration of the initial 45 day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render the decision. If, prior to the end of the first 30 day extension period, the Organization determines that, due to matters beyond its control of the Organization, the decision cannot be rendered within the extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Organization notifies the claimant, prior to the expiration of the first 30 day extension period, of the circumstances requiring the extension and the date by which the Organization expects to render a decision. In the case of any extension under this paragraph, the Notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specific information.

11.06 Calculating Time Periods.

For purposes of Sections 11.03, 11.04, and 11.05, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted under Section 11.04(c) or (d) or 11.05 due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

11.07 Manner and Content of Notification of Benefit Determination.

In the event of an Adverse Benefit Determination, the claimant shall be provided written or electronic Notice of such determination, which Notice shall be written in language calculated to be understood by the claimant.

(a) In General (for All Claims for Benefits). The Notice shall set forth the following information:

(i) The specific reason(s) for the adverse determination;

(ii) Reference to specific Plan provisions, including any Coverage Document provisions, on which the determination is based;

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

(iv) A description of the Plan's claim review procedures and the time limits applicable to such procedures, including, if applicable, a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on review.

(b) Group Health Plan Claims. Further, in case of an Adverse Benefit Determination by a Group Health Plan, the Notice shall also set forth the following, to the extent applicable:

(i) *In General*.

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; and

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.

(ii) *Claims Involving Urgent Care*. In addition, in case of an Adverse Benefit Determination by a Group Health Plan that is Concerning a Claim Involving Urgent Care, the Notice shall also provide a description of the expedited review process applicable to such claims, and the determination Notice information described above may be provided to the claimant orally within the time frame prescribed above, provided that a written or electronic Notification is furnished to the claimant not later than 3 days after the oral Notification.

(iii) *Additional Requirements under the Affordable Care Act*. Finally, in the case of an Adverse Benefit Determination by a Group Health Plan that is not an Excepted Benefit, if and to the extent required by the Affordable Care Act guidance:

1) The Notice shall also provide information sufficient to identify the claim involved, including, as applicable, the date of service, the health care provider, the claim amount, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.

2) The Organization must provide to Covered Persons, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and/or the treatment code and its corresponding meaning, associated with any Adverse Benefit Determination (and any such request shall not be considered a request for appeal under Section 11.08 or a request for external review under Section 11.12(c)).

3) The Notice shall also include, as applicable: (A) the denial code and its corresponding meaning, as well as a description of the standard that was used (if any) in denying the claim; (B) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and (C) a description of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHS Act to assist individuals with the internal claims and appeals and external review processes.

(c) Disability Claims. Further, in case of an Adverse Benefit Determination by a plan providing disability benefits, the Notice shall also set forth the following, to the extent applicable:

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (B) the views 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 (C) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;

(ii) 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;

(iii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

(iv) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the claimant's claim for benefits.

11.08 Appeal of Adverse Benefit Determination.

(a) General Rule. Upon receipt of such Notice of an Adverse Benefit Determination, or if such a Notice is not furnished but the claim has not been granted within the specified time period (or any valid extension thereof) described in this Article XI, the claimant may appeal to the applicable Reviewing Fiduciary for a full and fair review by written application to the Reviewing Fiduciary. Except as otherwise provided in this Section 11.08 or in the applicable Coverage Document, claimants must appeal an Adverse Benefit Determination within 60 days following receipt of the Notification of the decision.

In submitting a request for review, the claimant may have reasonable access to, and copies of, documents, records, and other information Relevant to the claimant's claim of benefits, free of charge, and may submit in writing issues, comments, documents, records, and any other information relating to the claim of benefits. Any such supplemental information shall be considered upon review of the claim without regard to whether such information was submitted or considered in the initial benefit determination.

(b) Group Health Plans or Plans Providing Disability Benefits. Notwithstanding the above, and in addition to complying with the above requirements of accessing records and submitting additional information with respect to the claimant's claim, in the case of a Group Health Plan or a plan providing disability benefits, the following procedures shall apply:

(i) *In General*.

1) Claimants shall be provided at least 180 days following receipt of a Notification of an Adverse Benefit Determination within which to appeal the determination;

2) The Plan shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate Reviewing Fiduciary who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

3) The Plan shall 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;

4) The Plan shall 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;

5) The Plan shall provide that the Health Care Professional engaged for purposes of a consultation under this Section 11.08 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; and

6) The Plan shall provide, in the case of a Claim Involving Urgent Care, for an expedited review process pursuant to which: (A) a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the claimant; and (B) all necessary information, including the benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

(ii) *Group Health Plans to which the Affordable Care Act Applies*. In the case of a Group Health Plan that is not an Excepted Benefit and to which the Affordable Care Act applies, the following additional procedures shall also apply (if and to the extent required by the Affordable Care Act guidance):

1) The Plan shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided under

subsection (c) (pursuant to 29 C.F.R. § 2560.503-1(i)) to give the claimant a reasonable opportunity to respond prior to that date; and

2) Before the Plan can issue a final internal Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided under subsection (c) (pursuant to 29 C.F.R. § 2560.503-1(i)) to give the claimant a reasonable opportunity to respond prior to that date. Notwithstanding the rules of 29 C.F.R. § 2560.503–1(i), if the new or additional evidence is received so late that it would be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal Adverse Benefit Determination is tolled until such time as the claimant has a reasonable opportunity to respond. After the claimant responds, or has a reasonable opportunity to respond but fails to do so, the Plan shall notify the claimant of the Plan's benefit determination as soon as a plan acting in a reasonable and prompt fashion can provide the Notice, taking into account the medical exigencies.

(iii) *Plans Providing Disability Benefits*. In the case of a plan providing disability benefits, the following additional procedures shall also apply:

1) Before the Plan can issue an Adverse Benefit Determination on review of a disability benefit claim, the claimant must be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided under 29 C.F.R. § 2560.503-1(i) to give the claimant a reasonable opportunity to respond prior to that date; and

2) Before the Plan can issue an Adverse Benefit Determination on review on a disability benefit claim based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided under 29 C.F.R. § 2560.503-1(i) to give the claimant a reasonable opportunity to respond prior to that date.

(c) Timing of Notification of Benefit Determination on Review.

(i) *General Rule*. The Reviewing Fiduciary shall respond promptly to such a request for review and shall deliver a written decision, which shall include, in a manner calculated to be understood by the claimant, the decision itself, specific reasons therefor, and specific references to the pertinent Plan provisions on which the decision is based. The decision on review shall be made by the Reviewing Fiduciary not later than 60 days after the Reviewing Fiduciary's receipt of a request for review, unless special circumstances require extension of time for processing such claim, in which case a decision shall be made within 120 days after the Reviewing Fiduciary's receipt of request for review. If such an extension for special circumstances is necessary, then the claimant shall be given written Notice of the extension prior to the expiration of such 60 day period. Such written Notice shall indicate the special circumstances requiring an extension of time and the date by which the Reviewing Fiduciary expects to render the determination on review.

(ii) *Group Health Plans*. For claims involving a Group Health Plan benefit, the Reviewing Fiduciary shall notify a claimant of the benefit determination on review in accordance with the following three paragraphs.

1) Urgent Care Claims. In the case of a Claim Involving Urgent Care, the Reviewing Fiduciary shall notify the claimant, in accordance with the Notice requirements set forth herein, of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an Adverse Benefit Determination by the Reviewing Fiduciary.

2) Pre-Service Claims. In the case of a Pre-Service Claim, the Reviewing Fiduciary shall notify the claimant, in accordance with the Notice requirements set forth herein, of the benefit determination on review within a reasonable period of time appropriate to the medical circumstances. In case of a Group Health Plan that provides for one appeal of an Adverse Benefit Determination, such Notification shall be provided not later than 30 days after receipt by the Reviewing Fiduciary of the claimant's request for review of an Adverse Benefit Determination. In case of a Group Health Plan that provides for two appeals of an adverse determination, such Notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the Reviewing Fiduciary of the claimant's request for review of the adverse determination.

3) Post-Service Claims. In the case of a Post-Service Claim, the Reviewing Fiduciary shall notify the claimant, in accordance with the Notice requirements set forth herein, of the benefit determination on review within a reasonable period of time. In case of a Group Health Plan that provides for one appeal of an Adverse Benefit Determination, such Notification shall be provided not later than 60 days after receipt by the Reviewing Fiduciary of the claimant's request for review of an Adverse Benefit Determination. In case of a Group Health Plan that provides for two appeals of an adverse determination, such Notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the Reviewing Fiduciary of the claimant's request for review of the adverse determination.

(iii) *Disability Claims*. Claims involving disability benefits (whether the disability plan provides for one or two appeals) shall be governed by subsection (c)(i) above except that a period of 45 days shall apply instead of 60 days.

11.09 Calculating Time Periods for Appeals.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted herein due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the Notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

11.10 Furnishing Documents.

In the case of an Adverse Benefit Determination on review, the Reviewing Fiduciary shall provide such access to, and copies of, documents, records, and other information described in Section 11.11 below, as is appropriate.

11.11 Manner and Content of Notification of Benefit Determination on Review.

The Reviewing Fiduciary shall provide the claimant with written or electronic Notice of its benefit determination on review, which Notice shall be written in a manner calculated to be understood by the claimant.

(a) In General (for All Claims for Benefits). The Notice shall set forth the following information, as applicable:

(i) The specific reason(s) for the adverse determination;

(ii) Reference to the specific Plan provisions, including any Coverage Document provisions, on which the determination is based;

(iii) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the claimant's claim for benefits; and

(iv) If applicable, a statement describing any voluntary appeal procedures offered by the Plan (and the claimant's right to obtain information about such procedures), and a statement of the claimant's right to bring an action under Section 502(a) of ERISA.

(b) Group Health Plan Claims. Further, in case of a Group Health Plan, the Notice shall also set forth the following, to the extent applicable:

(i) *In General*.

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 rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

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; and

3) The following statement, only if and to the extent applicable and required by law: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(ii) *Additional Requirements under the Affordable Care Act*. In the case of an Adverse Benefit Determination by a Group Health Plan that is not an Excepted Benefit, if and to the extent required by the Affordable Care Act guidance:

1) The Notice shall also provide information sufficient to identify the claim involved, including, as applicable, the date of service, the health care provider, the claim amount, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.

2) The Reviewing Fiduciary must provide to Covered Persons, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and/or the treatment code and its corresponding meaning, associated with any Adverse Benefit Determination or final Adverse Benefit Determination (and any such request shall not be considered a request for appeal under Section 11.08 or a request for external review under Section 11.12(c)).

3) The Notice shall also include, as applicable: (A) the denial code and its corresponding meaning, as well as a description of the standard that was used (if any) in denying the claim, and, for a final internal Adverse Benefit Determination, a discussion of the decision; (B) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and (C) a description of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHS Act to assist individuals with the internal claims and appeals and external review processes.

(c) Disability Claims. Further, in case of a plan providing disability benefits, the Notice shall also set forth the following, to the extent applicable:

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (B) the views 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 (C) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;

(ii) 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;

(iii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

(iv) With respect to the statement of the claimant's right to bring an action under Section 502(a) of ERISA, a description of any applicable contractual limitations period that applies to that right to bring such an action, including the calendar date on which the contractual limitation period expires for the claim.

11.12 Additional Requirements under the Affordable Care Act Guidance.

To the extent required by the Affordable Care Act guidance, with respect to a Group Health Plan that is not an Excepted Benefit, the following shall apply, in addition to the other applicable requirements of this Article XI:

(a) Deemed Exhaustion of Internal Claims and Appeals Procedures. In the event the Plan fails to adhere to the requirements of 29 C.F.R. § 2590.715-2719(b)(2), the claimant will be deemed to have exhausted internal claims and appeals process of 29 C.F.R. § 2590.715-2719(b), except with regard to *de minimis* violations as described in (and subject to the requirements of) 29 C.F.R. § 2590.715-2719(b)(2)(ii)(F)(2), and such claimant therefore (i) may initiate the external review procedures described in subsection (c), as applicable, and/or (ii) may pursue any available remedies under Section 502(a) of ERISA.

(b) Requirement to Provide Continued Coverage Pending the Outcome of an Appeal. To the extent a claim is subject to the requirements of 29 C.F.R. § 2590.715-2719(b)(2), the Plan will provide continued coverage pending the outcome of an appeal in accordance with the requirements of Section 11.04(b) (pursuant to 29 C.F.R. § 2560.503-1(f)(2)(ii)), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

(c) External Review Procedures. The Plan shall provide the external review process required, as applicable, by either:

(i) The state external review process conducted by an Independent Review Organization that applies to and is binding on the Insurer, in accordance with 29 C.F.R. § 2590.715-2719(c); or

(ii) If the Plan is not subject to a state external review process, the federal external review process conducted by an Independent Review Organization in accordance with 29 C.F.R. § 2590.715-2719(d), with respect to either:

1) A Rescission of coverage, regardless of whether the Rescission has any effect on any particular benefit at that time; or

2) An Adverse Benefit Determination (including a final internal Adverse Benefit Determination) that involves medical judgment, as determined by the external reviewer. For this purpose, determinations that involve "medical judgment" include those made (A) based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; (B) to determine whether a treatment is experimental or investigational; (C) to determine whether a Covered Person is entitled to a reasonable alternative standard for a reward under a wellness program; (D) to determine compliance with the nonquantitative treatment limitation provisions of Section 9812 of the Code (which generally require, among other things, parity in the application of medical management techniques). Determinations that involve "medical judgment" do not include any denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that the individual fails to meet the requirements for eligibility under the terms of the Plan.

(d) Avoiding Conflicts of Interest. The Plan shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be based upon the likelihood that the individual will support the denial of benefits.

(e) Culturally and Linguistically Appropriate Notices. Relevant Notices from the Plan shall be provided in a culturally and linguistically appropriate manner. For this purpose, "culturally and linguistically appropriate manner" includes all of the following with respect to an address in any United States county to which a Notice is sent, if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary of Labor (an "applicable non-English language"):

(i) The Plan shall provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review as described in subsection (c) above) in any applicable non-English language;

(ii) The Plan shall provide, upon request, a notice in any applicable non-English language; and

(iii) The Plan must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan.

11.13 Additional Requirements Applicable to Claims for Disability Benefits.

With respect to claims for disability benefits, the following shall also apply, in addition to the other applicable requirements of this Article XI:

(a) Deemed Exhaustion of Claims and Appeals Procedures. In the event the Plan fails to strictly adhere to the requirements of 29 C.F.R. § 2560.503-1, the claimant will be deemed to have exhausted the administrative remedies available under the Plan, except with regard to *de minimis* violations as described in (and subject to the requirements of) 29 C.F.R. § 2560.503-1(l)(2)(ii), and such claimant therefore may pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If the claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(b) Avoiding Conflicts of Interest. The Plan shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

(c) Culturally and Linguistically Appropriate Notices. Relevant Notices from the Plan shall be provided in a culturally and linguistically appropriate manner. For this purpose, "culturally and linguistically appropriate manner" shall have the meaning ascribed to it in Section 11.12(e) (including in subsections (i) – (iii) therein), above.

11.14 Discounts and Waivers.

Notwithstanding anything to the contrary elsewhere herein, and except as otherwise provided in an applicable Coverage Document or in an applicable Administrative Services Agreement or Provider Group Contract or as required by applicable law, when determining the amount of benefits payable on behalf of a specific Participant or other Covered Person hereunder, the applicable Organization or Reviewing Fiduciary, as applicable, shall take into account any network, contracted, preferred, or similar provider (by whatever name called), or similar discount to be applied, or any waiver of all or a portion of charges made (or to be made) by any non-network, non-contracted, non-preferred, or similar provider (by whatever name called) for the services provided to or with respect to that Covered Person, and shall thereafter base the coinsurance and any other cost-sharing portion of the benefits to be paid by the Covered Person on the actual, resulting cost of the covered services or supplies being provided, after application of any and all such discounts and/or waivers.

11.15 Errors.

An administrative or clerical error when determining eligibility or benefits or maintaining Plan records shall not place in force any coverage or benefits not provided under the Plan, void any valid coverage or benefits provided under the Plan, or extend any coverage or benefits that have otherwise terminated. When an administrative or clerical error becomes known, the Plan Administrator shall cause all proper and equitable adjustments to be made, including any adjustment to any required contributions as necessary to correct the error (to the extent permitted by law).

In no event shall the Company or any other Employer or the Plan Administrator, the Organization, the Reviewing Fiduciary, or other fiduciary of the Plan be liable in any manner for any administrative or clerical error, or for any other determination of fact, made in good faith.

11.16 Limitations/Restrictions on Lawsuits.

(a) The Plan Administrator and Reviewing Fiduciary, in carrying out their duties and responsibilities hereunder, shall have full and absolute power and discretion to construe all terms of the Plan, and to determine all questions relating to eligibility to participate and the eligibility for benefits under the Plan, and the decisions of the Plan Administrator or Reviewing Fiduciary, as the case may be, shall be final and legally binding upon all interested parties, including, but not limited to, the Employer, Employees, Participants and other Covered Persons, and beneficiaries. Any interpretation, determination, or other action of the Plan Administrator or Reviewing Fiduciary

shall be subject to review only if such decision or action was arbitrary or capricious or otherwise an abuse of discretion.

(b) No legal action may be maintained against the Company, an Employer, the Plan, or the Plan Administrator, the Reviewing Fiduciary, or any other fiduciary until the claim procedures prescribed by this Article XI and the applicable Coverage Document(s) have been exhausted. All actions and claims for benefits filed in a court shall be determined based upon a review of the administrative record that was presented to or considered by the Reviewing Fiduciary during the claim procedure process and all other records that were before the Reviewing Fiduciary when the claim was decided, and no person shall be entitled to a trial de novo before any court whereby that person is claiming entitlement to benefits under this Plan.

(c) Except as otherwise expressly provided in a Coverage Document or required by applicable law, no legal action may be maintained against the Company, an Employer, the Plan, or the Plan Administrator, the Reviewing Fiduciary, or any other fiduciary after one (1) year following the later of (i) the date on which the claim arose or (ii) the date on which all claim procedures prescribed by this Article XI (other than in Section 11.12(c)) have been exhausted or are deemed exhausted under applicable law.

(d) Except as otherwise expressly provided in a Coverage Document, the restrictions on forum and venue set forth in Section 13.02(b) shall apply.

ARTICLE XII.
PROTECTED HEALTH INFORMATION

12.01 Purpose and Applicability.

This Article XII is intended to reflect the Plan's compliance with HIPAA and the privacy and security regulations promulgated pursuant thereto at 45 C.F.R. parts 160 and 164 (all collectively referred to in this Article XII as the "HIPAA regulations"; with 45 C.F.R. § 164.504(f) specifically referred to in this Article XII as "the 504 provisions"), by establishing the extent to which the Company, as sponsor of the Plan, will receive, use and/or disclose "protected health information" as that term is defined in the HIPAA regulations ("Protected Health Information").

The Plan is a "hybrid entity" as that term is defined in the HIPAA regulations. This Article XII shall apply only with respect to benefits under the Plan that constitute "health plans" as that term is defined in the HIPAA regulations, and such benefits are hereby designated as the "health care components" of the Plan.

12.02 Definitions.

All terms defined in the HIPAA regulations (and not defined in this Article XII or elsewhere in the Plan) shall have the meaning set forth therein, regardless of whether such terms are capitalized in this Article XII. The following definitions apply to the provisions set forth in this Article XII and in Appendices C and D (and in the Certification of HIPAA Compliance attached) to this Plan.

(a) "**Plan**" means the Ryman Hospitality Properties Employee Health and Welfare Plan, limited to the health care components of such Plan.

(b) "**Plan Documents**" mean the Plan's governing documents and instruments (i.e., the documents under which the Plan was established and is maintained, as such are amended from time to time) including, but not limited to, this document and the applicable Coverage Document(s).

(c) "**Plan Sponsor**" means the "plan sponsor" as defined in Section 3(16)(B) of ERISA, 29 U.S.C. § 1002(16)(B). The Plan Sponsor is the Company, when acting in its role as the sponsor of the Plan (rather than as the Plan Administrator).

12.03 The Plan's Disclosure of Protected Health Information to the Plan Sponsor—Required Certification of Compliance by Plan Sponsor.

Except as otherwise provided in Section 12.08 below, the Plan will (i) disclose Protected Health Information to the Plan Sponsor, or (ii) provide for or permit the disclosure of Protected Health Information to the Plan Sponsor by a health insurance issuer or HMO with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

(a) the Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the 504 provisions;

(b) the Plan Documents have been amended to incorporate the Plan provisions set forth below in this Article XII; and

(c) the Plan Sponsor agrees to comply with the Plan provisions set forth below in this Article XII.

12.04 Permitted and Required Uses and Disclosures of Protected Health Information by the Plan Sponsor.

The Plan Sponsor shall only use and disclose Protected Health Information:

(a) to carry out plan administration functions on behalf of the Plan;

(b) that constitutes summary health information, in accordance with Section 12.05(a) below;

(c) pursuant to, and in accordance with, a valid authorization that complies in all applicable respects with 45 C.F.R. § 164.508 (including for the purpose(s) of, without limitation, employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor);

(d) as required by law; and

(e) as otherwise permitted or required by the HIPAA regulations or other applicable law.

Except as provided in Section 12.08, such uses and disclosures will be consistent with the provisions of this Article XII and the 504 provisions.

12.05 Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor.

(a) Except as prohibited by 45 C.F.R. § 164.502(a)(5)(i) (specifically prohibiting the use and disclosure of genetic information for underwriting purposes), the Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

(i) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

(ii) modifying, amending, or terminating the Plan.

(b) The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose enrollment and disenrollment information (each, within the meaning of 45 C.F.R. § 164.504(f)(1)(iii)) to the Plan Sponsor, and such information, while in the possession of the Plan Sponsor, shall not be considered Protected Health Information and shall not be subject to the 504 provisions.

12.06 With Respect to Protected Health Information, the Plan Sponsor Agrees to Certain Conditions.

Except with respect to the information described in Section 12.08 below, the Plan Sponsor:

(a) will not use or further disclose the Protected Health Information other than as permitted or required by the Plan Documents or as required by law;

(b) will ensure that any agent(s) to whom it provides Protected Health Information received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information;

(c) will not use or disclose Protected Health Information for employment-related actions and decisions;

(d) will not use or disclose Protected Health Information in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(e) will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents and in the 504 provisions of which the Plan Sponsor becomes aware;

(f) will make available Protected Health Information in accordance with 45 C.F.R. § 164.524;

(g) will make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. § 164.526;

(h) will make available the Protected Health Information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;

(i) will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA regulations;

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

(k) will ensure that the required adequate separation, described in Section 12.07 below, is established and maintained; and

(l) will, to the extent the Plan Sponsor creates, receives, maintains, or transmits electronic Protected Health Information ("e-PHI") on behalf of the Plan:

(i) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI;

(ii) ensure that the adequate separation between the Plan and the Plan Sponsor as set forth in 45 C.F.R. § 164.504(f)(2)(iii) (and described in Section 12.07 below) is supported by reasonable and appropriate security measures;

(iii) ensure that any agent to whom it provides this e-PHI agrees to implement reasonable and appropriate security measures to protect the information; and

(iv) report to the Plan any security incident of which it becomes aware; provided, however, that the Plan and Plan Sponsor acknowledge and agree that this provision constitutes notice by Plan Sponsor to Plan of the ongoing existence and occurrence of attempted but *unsuccessful* security incidents for which no additional notice to Plan shall be required ("*unsuccessful* security incidents" shall include, but not be limited to, pings and other broadcast attacks on Plan Sponsor's firewall, port scans, unsuccessful log-on attempts, denials of service, and any combination of the above, so long as no such incident results in unauthorized access, use, or disclosure of e-PHI).

12.07 Adequate Separation between the Plan and the Plan Sponsor.

The Plan Sponsor will ensure the adequate separation between the Plan and the Plan Sponsor's other operations by complying with the following:

(a) Only the employees and/or employment classifications or other persons under the control of Plan Sponsor incorporated within the Plan's HIPAA privacy and security policies and procedures (and which must include any employee or person who receives Protected Health Information relating to the payment under, health care operations of, or other matters pertaining to, the Plan in the ordinary course of business) will be allowed access to Protected Health Information.

(b) The Plan Sponsor will restrict the access of such Protected Health Information to plan administration functions as performed by the Plan Sponsor for the Plan.

(c) The Plan Sponsor will provide an effective mechanism for resolving any violations of this Article XII and the 504 provisions by the persons described in clause (a). Such mechanism is set forth in the Plan's HIPAA privacy and security policies and procedures.

12.08 Information Not Subject to Sections 12.06 and 12.07.

Notwithstanding anything else herein to the contrary, the terms of Sections 12.06 and 12.07 above shall not apply to:

(a) summary health information or enrollment and disenrollment information provided to the Plan Sponsor pursuant to 45 C.F.R. § 164.504(f)(1)(ii) or (iii), respectively (and described in Section 12.05 above);

(b) Protected Health Information released pursuant to a valid authorization that complies in all applicable respects with 45 C.F.R. § 164.508; or

(c) other circumstances permitted by the HIPAA regulations.

ARTICLE XIII.
GENERAL PROVISIONS

13.01 Limitation of Rights.

Neither the establishment or maintenance of this Plan nor any amendment hereof, nor the payment of any benefits, will be construed as giving to any Employee or other person any legal or equitable right against the Company, an Employer, the Plan Administrator, or any fiduciary, except as provided herein. Neither the establishment or maintenance of this Plan nor any amendment hereof, nor the payment of benefits, nor any action taken with respect to this Plan shall confer upon any person the right to be continued in the employment of any Employer, or upon dismissal or involuntary termination of employment to have any right or interest in the Plan other than as expressly provided herein.

13.02 Governing Law and Restrictions on Forum and Venue.

(a) Governing Law. Except to the extent federal law is controlling, the provisions of this Plan shall be interpreted and construed according to the laws of the State of Tennessee, except for those matters specifically governed by the laws of the Company's jurisdiction of formation (the State of Delaware).

(b) Restrictions on Forum and Venue. Except as otherwise expressly provided in a Coverage Document or in an Administrative Services Agreement or Provider Group Contract, if applicable, actions in connection with the Plan may only be brought in court of competent jurisdiction in the Middle District of Tennessee, and such court shall have exclusive jurisdiction over any such action.

13.03 Headings.

The headings and subheadings of articles and sections are included in the Plan solely for convenience of reference, and if there be any conflict between such headings and the text of the Plan, then the text of the Plan shall control.

13.04 Gender and Number.

Whenever any words are used herein in any gender, they shall be construed as though they were also used in any and all genders in all cases where they would so apply; and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

13.05 Statutory and Regulatory References.

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

Any reference herein to a section of the Code of Federal Regulations ("C.F.R.") shall mean the cited section as in effect or as such may be amended or replaced from time to time, and for which compliance by or with respect to the Plan is required.

13.06 Severability of Provisions.

The provisions of this Plan are severable, and should any provision be determined (by the Plan Administrator) or ruled illegal, unenforceable, inapplicable, or void, all other provisions not so determined or ruled shall remain in full force and effect. The remaining provisions of the Plan shall be construed in a manner that maximizes compliance with the objectives of the Plan, as drafted.

13.07 Entire Plan.

This Plan document, including the appendices attached hereto and the Coverage Documents (and any other documents, laws, etc. specifically incorporated hereinto by reference), constitutes the entire benefit

plan for the Participants. No modifications or alterations to this Plan shall be enforceable unless properly and validly made pursuant to the provisions of Article IX hereof.

13.08 Information to be Furnished.

Each Employee and Covered Person shall provide the Plan Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested or required from time to time for the purpose of administration of the Plan.

13.09 Payment from General Assets.

Except as otherwise provided pursuant to Sections 5.02 and 5.03, the benefits provided under this Plan are paid solely from the general assets of the Employer. Nothing herein will be construed to require an Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of the Employer from which any payment under the Plan may be made.

13.10 Inability to Locate or Contact Payee; Forfeiture of Uncashed Checks.

Except as otherwise expressly provided in a Coverage Document or required by law, if the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of, or has been able to contact, such Participant or other person after reasonable efforts have been made to identify, locate, or contact such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment(s) first became payable.

Except where prohibited by law, if the Plan Administrator, Insurer, or a Claims Administrator issues a check to pay benefits owed to a Participant under the Plan, and the Participant fails to cash the check within twelve (12) months from the date that the check is issued, the Participant forfeits the amount reflected on the check and such amount shall cease to be a liability of the Plan, so long as the Plan Administrator, Insurer, or Claims Administrator exercises reasonable care in attempting to make the payment and, for amounts exceeding fifty dollars ($50.00), distributes a notice to the last known address of the Participant prior to the forfeiture.

13.11 Facility of Payment.

If any dispute arises as to the proper recipient of any payment, the Plan Administrator, in its sole discretion, may withhold, or cause to be withheld, delivery of such payment until the dispute shall have been settled by the parties concerned or shall have been determined by a court of competent jurisdiction.

If the Plan Administrator receives evidence satisfactory to it that a person entitled to receive any benefit under the Plan is physically or mentally incompetent to receive such benefit and to give a valid release and that another person or institution is then maintaining or has custody of such person, unless the claim shall have been made by a duly appointed guardian, committee, or other legal representative, the Plan Administrator may authorize payment of such benefit to such other person or institution and the release of such other person or institution shall be a valid and complete discharge for the payment of such benefit.

13.12 Limitation on Liability for Insured, etc. Benefits.

Except as otherwise expressly provided therein, the Employer does not guarantee benefits payable under any Insurance Contract or Provider Group Contract, or any insurance policy or other similar contract described or referred to in the Plan, and any benefits thereunder shall be the exclusive responsibility of the Insurer, Provider Organization, or other entity that is required to provide such benefits under the policy or contract.

13.13 Liability of Officers and Employees.

No officer or employee of the Company (or any other Employer) shall incur any personal liability of any nature for any act done or omitted to be done in good faith in connection with their duties relative to the Plan, except in cases of gross negligence or willful misconduct. Such officers and employees shall be indemnified and saved harmless by the Employer from and against any liability to which any of them may

be subjected by reason of any act done or omitted to be done in good faith, including all expenses reasonably incurred in their defense to the extent permitted by law. Any indemnification payments made by reason of this Section 13.13 shall not be made from any assets of the Plan.

13.14 Physical Examination.

The Plan Administrator shall have the right and opportunity to have examined by a physician it designates, any person whose injury, illness, or condition is the basis of a claim hereunder, when and so often as it may reasonably require during the pendency of such claim.

13.15 No Effect on Workers' Compensation.

The Plan is not in lieu of and does not affect any requirement for coverage under a workers' compensation or similar state law.

13.16 Exclusive Benefit.

The Plan is maintained for the exclusive benefit of persons entitled to participate in the Plan (and their beneficiaries), and no third party shall have any rights under the Plan, except as expressly provided in the Plan.

13.17 Tax Effects.

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

13.18 Reliance.

The Company, an Employer, the Plan Administrator, and any person or persons involved in the administration of the Plan shall be entitled to rely upon any certification, statement, or representation made or evidence furnished by a Participant or other Covered Person with respect to their age, health, or other facts required to be provided under any of the provisions of the Plan, and shall not be liable on account of the payment of or enrollment for any benefits or the doing of any act or failure to act in reliance thereon. Any such certification, statement, representation, or evidence, upon being duly made or furnished, shall be conclusively binding upon the person furnishing same; but it shall not be binding upon the Company, the Employer, the Plan Administrator, or any other person or persons involved in the administration of the Plan, and nothing herein contained shall be construed to prevent any of such parties from contesting any such certification, statement, representation, or evidence or to relieve the Covered Person from the duty of submitting satisfactory proof of any such fact.

13.19 Plan Representations.

Except as otherwise specifically provided in the Plan (including in any Coverage Document), any statement or representation, whether oral, written, electronic, or otherwise, made by an employee or other representative of any Employer, Claims Administrator, Insurer, any other service provider, or any other individual or entity that alters, modifies, amends or is inconsistent with the written terms of the official plan documents of the Plan shall be invalid and unenforceable and may not be relied upon by any Covered Person, beneficiary, Claims Administrator, Insurer, any other service provider, or any other individual or entity.

13.20 Fraud.

Any individual who knowingly and willfully executes, or attempts to execute, a scheme to defraud the Plan, or to obtain by means of false or fraudulent pretenses, any of the money or property owned by or under the control of the Employer or the Plan, may be immediately terminated from coverage under the Plan. Further, any individual who knowingly and willfully falsifies, conceals, or covers up any material fact, or makes any materially false, fictitious, or fraudulent statements in connection with the individual's

enrollment in the Plan or the receipt of health care benefits under the Plan, may be immediately terminated from coverage under the Plan. Such termination may be made retroactively, except to the extent prohibited by the Affordable Care Act or other applicable law (and any such Rescission shall be treated as an Adverse Benefit Determination and administered accordingly, as required by law).

Examples of conduct that violates the above provisions include knowingly and intentionally:

- filing claims that contain false, incomplete, or misleading information;
- misrepresenting the eligibility of a Dependent or other person for coverage or benefits under the Plan, including a failure to notify the Plan Administrator of a change that would cause a Dependent or other person to cease to be eligible for coverage or benefits;
- failing to bring to the attention of the Plan Administrator or its delegate (e.g., the Claims Administrator or a Reviewing Fiduciary) material information the individual knows to be incorrect;
- using or permitting someone else to use an identification card for unauthorized purposes; or
- any other conduct (or failure to act) that defrauds or deceives the Plan.

Any such conduct (or failure to act) may be considered by the Plan Administrator to constitute fraud and/or intentional misrepresentation of material fact.

In addition, to the fullest extent permitted by law, the Plan Administrator has the right to seek full recovery of any losses from, and to pursue criminal and civil prosecution against, any such individual(s).

13.21 Compliance with All Applicable Federal Mandates.

Notwithstanding anything in the Plan to the contrary, this Plan shall be operated in accordance with the requirements of all applicable laws including, but not limited to, those set forth below, the provisions of each of which are hereby incorporated by reference into the Plan:

(a) the FMLA;

(b) HIPAA, including as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act);

(c) COBRA;

(d) USERRA (provided, however, that to the extent any employee is eligible for both COBRA and USERRA continuation of coverage at the same time, (i) the election of either COBRA or USERRA extension by an employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the employee will generally be extended; and (ii) coverage under both laws will run concurrently, to the extent permitted by law);

(e) the Women's Health and Cancer Rights Act of 1998 (WHCRA);

(f) the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA);

(g) the Mental Health Parity Act of 1996 (Mental Health Parity) and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);

(h) the Genetic Information Nondiscrimination Act of 2008 (GINA)

(i) Michelle's Law;

(j) the Affordable Care Act;

(k) the Consolidated Appropriations Act, 2021; and

(l) any relief or other guidance issued pursuant to Section 518 of ERISA and/or Section 7508A(b) of the Code.

The Plan Administrator has full power and discretion to cause the Plan to be so operated, including without limitation, the power to interpret, construe, and implement all applicable provisions of such laws in such manners as the Plan Administrator deems appropriate.

[*Remainder of page intentionally left blank; signature follows on next page.*]

IN WITNESS WHEREOF, the Benefits Trust Committee has caused this amended and restated Plan to be duly executed for and on its behalf by its duly authorized members, effective as of the Restatement Effective Date.

BENEFITS TRUST COMMITTEE

By:_____

Name:_____

Title:_____

Date:_____

APPENDIX A
TO THE
RYMAN HOSPITALITY PROPERTIES
EMPLOYEE HEALTH AND WELFARE PLAN

Coverage Documents

As of the Restatement Effective Date (except as otherwise specifically set forth below), the Coverage Documents under or pursuant to which premiums or contributions are paid and/or benefits are provided under the Plan are as follows:

- Medical, including Prescription Drug and other associated benefits and services[±]:
    - UMR Health Benefit Summary Plan Description for plan no. 7670-00-415099 with prescription drug coverage addendum and also including Lantern, and Vanderbilt MyHealth Bundles (MyOrthoHealth, MyHearingHealth, MyMaternityHealth, MyWeightLossHealth, MyUrology, MyRecoveryHealth, MyHeartHealth, MyOncologyHealth and MySpineHealth)
- Dental—Delta Dental of Tennessee contract for group no. 5880, and the corresponding Certificate of Coverage
- Vision—DeltaVision in partnership with VSP (underwritten by Delta Dental of Tennessee) contract for group no. V5880, and the corresponding Certificate of Coverage
- Short Term Disability—The Hartford Insurance Group Inc., Group Policy No. 715694, and the corresponding Group Short Term Disability Insurance Certificates
- Long-Term Disability—The Hartford Insurance Group Inc., Group Policy No. 715694, and the corresponding Group Long Term Disability Insurance Certificates
- Life (including basic and voluntary employee life, voluntary spouse or domestic partner life, and voluntary child life) Insurance—The Hartford Insurance Group Inc., Group Policy No. 715694, and the corresponding Group Life Insurance Certificates
- Accidental Death and Dismemberment (including basic and voluntary) Insurance— The Hartford Insurance Group Inc., Group Policy No. 715694, and the corresponding Group Accident Insurance Certificates
- EAP—Employee Assistance Program (EAP)—Aetna Behavioral Health, LLC contract no. 66066 (see Plan Overview and Administration Information booklet of the Summary Plan Description for details)
- Business Travel Accident—Life Insurance Company of North America Blanket Accident Policy No. ABL 962757

In addition, the Plan includes the Flexible Benefits Plan* (including the Health Flexible Spending Accounts and the Dependent Care Flexible Spending Account* offered thereunder).

In the event of amendment of this Appendix A, a new Appendix A may be attached to the Plan in place hereof without formal amendment to the Plan.

[±]Medical and Prescription Drug and other associated benefits and services constitute one "group health plan" for COBRA purposes.

[*] Not subject to ERISA (only the Health Flexible Spending Accounts offered under the Flexible Benefits Plan are subject to ERISA).

APPENDIX B
TO THE
RYMAN HOSPITALITY PROPERTIES
EMPLOYEE HEALTH AND WELFARE PLAN

Benefit Options under the Flexible Benefits Plan

The Benefit Options under or pursuant to which premiums or contributions are eligible for salary reduction under the Flexible Benefits Plan as of the Restatement Effective Date are as follows:

- Medical (including Prescription Drug) coverage under the Plan
- Dental coverage under the Plan
- Vision coverage under the Plan
- Health Flexible Spending Accounts
    - Health Care Flexible Spending Account (Health Care FSA), *not available to Participants enrolled in the "HDHP with HSA" medical coverage option under the Plan*
    - Limited Use Flexible Spending Account (Limited Use FSA), *available to Participants enrolled in the "HDHP with HSA" medical coverage option under the Plan*
- Dependent Care Flexible Spending Account (Dependent Care FSA)
- Health Savings Account (HSA), only available to Participants enrolled in the HDHP with HSA

In the event of amendment of this Appendix B, a new Appendix B may be attached to the Plan in place hereof without formal amendment to the Plan.

APPENDIX C
TO THE
RYMAN HOSPITALITY PROPERTIES
EMPLOYEE HEALTH AND WELFARE PLAN

Adoption by Affiliated Employers

As of the Restatement Effective Date, the following Affiliated Employers have adopted the Plan:

- None

In the event of amendment of this Appendix C, a new Appendix C may be attached to the Plan in place hereof without formal amendment to the Plan.

CERTIFICATION OF HIPAA COMPLIANCE
RYMAN HOSPITALITY PROPERTIES
EMPLOYEE HEALTH AND WELFARE PLAN[*]

The Company, as the Plan Sponsor of the Ryman Hospitality Properties Employee Health and Welfare Plan ("Plan"), hereby certifies that the Plan Documents incorporate the provisions set forth in Sections 12.06 and 12.07 of the Plan, as required by 45 C.F.R. § 164.504(f).

The Company also hereby certifies that it intends to conduct its relevant operations in accordance with such provisions. The Company understands that this certification is required by the Plan to comply with 45 C.F.R. § 164.504(f).

IN WITNESS WHEREOF, the Company, as Plan Sponsor of the Plan, has caused this Certification of HIPAA Compliance to be executed in its name and on its behalf by its duly authorized representative effective as of the Restatement Effective Date, *and to continue in effect any and all prior certification(s)*.

RYMAN CORPORATE PROPERTIES, LLC,
PLAN SPONSOR

By:_____

Title:_____

33903532.3

[*] All terms capitalized in this certification shall have the meanings set forth in Article XII of the Plan.