Rentokil North America, Inc.

SHORT-TERM DISABILITY PLAN

Effective January 1, 2024

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The Terminix Company, LLC Short-Term Disability Plan (the "Plan") is adopted by Rentokil North America, Inc. effective January 1, 2024, for the benefit of Eligible Colleagues. This Plan replaces and supersedes the short-term disability plan for Eligible Colleagues in effect all prior years.

The purpose of the Plan is to provide Participants with short-term salary continuation in the event of partial or total Disability due to a non-work-related Illness or Injury.

Benefits under the Plan are separate and distinct from Family Medical Leave Act ("FMLA") leave and Paid Vacation, Paid Sick Time-Off, and other company leaves (see the separate FMLA, PTO, and Leave policies). However, in certain cases benefits under the Plan, FMLA and PTO may be required to run concurrently. Note that PTO benefits under this Plan may be used to provide some level of income continuance while on FMLA leave (subject to the requirements below and subject to all relevant policies).

I. DEFINITIONS

Claims Administrator means the person hired by the Company to administer claims and payment of benefits under the Plan. The Claims Administrator is currently AbsenceOne.

Company means Rentokil and any successor thereto. The Company reserves the right to delegate any or all of its rights or obligations under the Plan to a third party administrator; provided that the Company shall retain the exclusive power to amend or terminate and to make any and all other decisions as Plan Sponsor.

Disability, Disabled or Disability means a Participant's inability to perform the duties of the Participant's regular occupation because of the disability, and must not be working in any occupation, as a direct result of a non-work-related Injury or Illness, and the Participant is receiving appropriate care and treatment from a medical professional and complying with the requirements of such treatment. The inability to perform work at a specific work location or worksite, solely because there is the risk of transmission of a specific Illness, is not considered a Disability if that individual is otherwise capable of performing his or her substantial and material duties of his or her position.

Eligible Plan Earnings for a calendar year (January 1 - December 31) are calculated using the gross annual income for the 12-month period ending August 31 of the previous year for colleagues who are in an eligible class as of August 31. For example, the Eligible Plan Earnings for calendar year 2024 are equal to the gross annual income from September 1, 2022 - August 31, 2023. Gross annual income includes total income before taxes and any payroll deductions for benefits. It includes base earnings, hourly pay, commissions, overtime, bonuses, and incentives. New hires will be given an annualized rate as of the date of hire. Coverage for the disability benefit is based on a Participant's Eligible Plan Earnings.

Eligible Colleague means a person who is an active, full-time colleague of the Company (or a participating subsidiary or affiliate of the Company) working at least thirty (30) hours per week. Part-time colleagues who work a minimum of twenty (20) hours per week are eligible after 12 months of service. The Company has the exclusive discretion to determine Colleague's eligibility for benefits under the Plan. The Company's determination will be final and binding on all persons.

Elimination Period means the period of time that a Participant must be Disabled before benefits will be payable under the Plan. See Section IV.A. below for additional detail.

Illness: means a disability which is:
1) caused or contributed to by:

a) any condition, illness, disease or disorder of the body;
b) any infection, except a puss-forming infection of an accidental cut or wound or bacterial infection resulting from an accidental ingestion of a contaminated substance;
c) hernia of any type unless it is the immediate result of an accidental Injury covered by the Plan; or
d) pregnancy;

2) caused or contributed to by any medical or surgical treatment for a condition shown in item 1) above.

Injury: means bodily injury resulting: 1) directly from accident; and 2) independently of all other causes; which occurs while the colleague is covered under the Plan. However, an Injury will be considered an Illness if an Eligible Colleague's disability begins more than 30 days after the date of the accident.

Participant means an Eligible Full-time Colleague at Date of Hire who has commenced participation in the Plan. Part-time colleagues are eligible after 12 months of service.

Physician means: 1) person performing tasks that are within the limits of his or her medical license; and 2) person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or 3) person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or 4) person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction. The Physician may not be the Participant, a relative by blood or marriage, or a domestic partner.

Plan means this document as may be amended from time to time.

II. PARTICIPATION

A. *Eligibility for Participation*

1. Eligible Colleagues must meet the following criteria to be eligible for the Plan:
2. Full-time colleagues working 30 hours per week are eligible immediately.
3. Part-time colleagues working 20-29 hours per week are eligible after 12 months of service.

B. *Enrollment Process*. *Coverage is automatic once an Eligible Colleague has met the eligibility waiting period definition.*

C. *Cessation of Participation*. A Participant will automatically cease to participate on the earliest of the following:

1. the date on which the Participant is no longer employed by the Company;
2. the date on which the Participant enters the armed services of any state or country on active duty; except for duty of 30 days or less for training in the Reserves or National Guard;
3. the date on which the Participant is covered under any other disability plan of the Company; and
4. the date on which the Participant ceases to be an Eligible Colleague.

III. ELIGIBILITY FOR BENEFITS

A. *Elimination Period.* A Participant who sustains a Disability will, subject to the provisions of the Plan, become eligible to receive benefits after a 7-day Elimination Period with benefits commencing as of the 8th full calendar day following his or her absent due to the Disability.

The 7-day elimination period will be waived in the event of a Disability that requires hospitalization, is caused by an accident, or for an eligible female colleague giving birth either prior to going on maternity leave or while on maternity leave and prior to the end of the 7-day elimination period, in which case the elimination period will end the day prior to delivery.

Subsequent periods of Disability separated by 15 or fewer days of continuous active employment at the Participant's normal work schedule will be considered one period of Disability, unless the subsequent Disability is due to an Illness or Injury to be entirely unrelated to the cause of the previous Disability and the Participant commences after return to active employment with the Company for at least 1 day.

A Participant may use available PTO, if applicable, during the Elimination Period. If the colleague does not have sufficient PTO to cover the Elimination Period, any remainder of the Elimination Period will be unpaid. If a Company-paid holiday falls during the Elimination Period, that holiday will count towards the Elimination Period, but the colleague will not be paid for the holiday as it is part of the Elimination Period.

B. *Subsequent Disabilities.* Subsequent periods of Disability separated by 15 or fewer days of continuous active employment at the Participant's normal work schedule will be considered one period of Disability, unless the subsequent Disability is due to an Illness or Injury to be entirely unrelated to the cause of the previous Disability and the Participant commences after return to active employment with the Company for at least 1 day.

C. *Disability Determination.* The Company will determine whether a Disability exists with respect to a Participant on the basis of any information the Company deems relevant to such determination. The Company's determination will be final and binding for all purposes.

D. *Exclusions.* No Participant will be entitled to a benefit under this Plan if:

1. his or her Disability is the result of an intentionally self-inflicted Injury or suicide attempt while sane or insane;
2. the Participant is not under the regular care of a Physician;
3. his or her Disability arises out of, relates to, is caused by or results from an Illness or Injury due to war (declared or undeclared) or any act of war;
4. his or her Disability arises out of or relates to the performance of a procedure performed for the purpose of improving the Participant's appearance, including but limited to abdominoplasty, blepharoplasty, neck tightening, or removal of redundant skin; breast augmentation; breast, brow, face, or forehead lifts; calf, cheek, chin, nose, or pectoral implants; collagen injections; facial bone reconstruction, reduction, or sculpturing, including jaw shortening and rhinoplasty; hair transplantation; lip reduction; liposuction; thyroid chondroplasty; and voice therapy, voice lessons, or voice modification surgery.
5. his or her Disability is the result of a sickness or injury covered under Workers' Compensation or similar coverage; and
6. his or her Disability arises out of (or in the course of) any employment for wage or profit, when the Disability would be covered by Workers' Compensation or similar coverage if: (a) the Company enrolls the Participant for such coverage; and (b) the Participant and Company cooperated in filing a claim under that plan.

IV. DISABILITY BENEFITS

A. *Amount of Benefit*. The Disability benefits payable under the Plan is equal to 66.67% of the Participant's Eligible Plan Earnings (or 80% of Eligible Plan Earnings after completing 5 years of

service with the Company*)*. In no event, however, will the weekly benefit exceed $3,460 or the monthly benefit exceed $15,000.

A Participant may **not** use available PTO to supplement the Participant's Disability benefits.

The maximum benefit a Participant can receive under this Plan is 13 weeks, except that maternity absences will be limited to 6 weeks for regular delivery or 8 weeks for cesarean delivery (unless continuing Disability is substantiated by the attending physician).

B. *Reductions to the Amount of Benefit*. Notwithstanding the above, the Disability benefit will be reduced by any of the following which are available to the Participant, or to the Participant's spouse or child(ren) if applicable, for the same period for which the Disability benefit is payable hereunder:

1. primary and dependent disability or retirement benefits under the Federal Social Security Act, or any similar plan or act; provided, however, that any cost-of-living increases in such benefits, effective after the initial reduction in the Plan benefit, will not serve to further reduce the Plan benefit;
2. benefits under any plan, fund or other arrangement, by whatever name called, providing disability benefits pursuant to any compulsory benefit act or law of any government;
3. benefits under a state-mandated disability plan or a Company plan established in lieu thereof; and
4. disability or retirement benefits under any other Company-sponsored or Company-funded plan.

If a Participant is or might be entitled to any of the above-itemized benefits, the full Plan benefit will be paid upon receipt by the Company of (i) evidence that the Participant has applied for such benefits and (ii) an executed agreement to reimburse the Plan, up to the amount of payments made, immediately upon receipt of such benefits.

If a Participant fails to apply for any of the above-itemized benefits to which he or she might be entitled, the Plan benefit will be reduced by the amount of the benefit which the Participant would have received had application been made. The Company will make determination of the amount of such benefit.

C. *Acts of Third Parties.* In the event that a Participant is injured through the acts or omissions of another person or organization, benefits under the Plan will be provided only on condition that the Participant agrees to the following:

1. to reimburse the Plan, for the full amount of payments made under the terms of the Plan, immediately upon receipt of the proceeds of any settlement of, or judgment in, an action at law, arbitration, claim, or other proceeding to determine his or her rights of recovery arising out of his or her Injury, net of his or her reasonable expenses in collecting such amount including reasonable attorney's fees, and net of any amounts which are allocated by terms of any judgment for the payment of unreimbursed medical expenses; he or she will execute and deliver instruments and papers and do whatever else is reasonably necessary to secure the rights of the Plan to reimbursement out of such proceeds, and he or she will do nothing to prejudice such rights;
2. to provide the Plan with a lien on the proceeds described in the preceding paragraph, to the extent of the full amount of payments made under the terms of the Plan; and

3. to provide the Plan with a credit against payments to be made in the future under the Plan equal to the proceeds described above, less any amount paid to the Plan by way of reimbursement.

D. *Suspension and Reinstatement of Benefits.* Disability benefits will be suspended as of the date of any medical examination conducted pursuant to Section VI.F. (Medical Examination). If the Company, on the basis of the results of such examination, determines that eligibility for benefits continues, benefits will be reinstated as of the date of the medical examination.

E. *Overpayments.* In the event the calculation of a benefit under the Plan results in an overpayment to the Participant, the Participant will be required to repay such overpayment. The Company will make reasonable arrangements with the Participant or his or her legal representative(s) for the repayment to the Plan, including, but not limited to, the reduction of future benefits under the Plan or the reduction of future pay from the Company. As required by some states, the Company will provide a payback agreement outlining the payback arrangement to the Participant for signature. If the Participant does not sign the payback arrangement legal action may be taken by the Company to recoup the overpayment, as well as possible disciplinary action.

V. PAYMENT OF BENEFITS

A. *Application for Benefits.* To be entitled to any benefits under the Plan, a Participant must comply with such procedures and requirements as the Company may have prescribed with respect to the completion and filing of an application for such benefits and submission of evidence that the Participant is entitled to such benefits. The Company may require information with respect to the Participant's age, address, marital status, dependents, employment record, medical history and evidence that the Participant has applied for any benefits which would serve to reduce benefits under this Plan.

The Company may require any other information reasonably relevant to a determination of whether the Participant is eligible to receive benefits and may also require written authorization to obtain:

1. information from the Participant's Physician with respect to his or her physical condition, diagnosis, prognosis, date of expected return to work and related matters;
2. relevant medical records on file in any hospital, Physician's or government office; and
3. such other records from any company having information reasonably relevant to a determination.

B. *Time Limit for Application for Benefits.* An application for benefits must be filed no later than 30 days after the date benefits may become payable under the Plan.

If the Participant or his or her representative fails to provide the information as required above, benefits will not be paid for the period during which the Participant was not in compliance with the Plan unless the Company determines, in its sole discretion, that the Participant's failure to comply was due to extenuating circumstances.

C. *Claim Processing*. All disability claims and appeals will be decided in a way that ensures the independence and impartiality of Plan decision-makers involved in the review process and avoids any conflicts of interest. Upon receipt of the Participant's application, the Claims Administrator will make a determination as to the eligibility of the Participant for benefits and notify the Participant of its decision to approve or deny the Participant's claim. Such notification will be mailed to the Participant within a reasonable period, not to exceed forty-five (45) days from the date the Participant submitted his or her claim, except for situations requiring an extension of time because of matters beyond the control of the

Plan. In such cases, the Claims Administrator may have up to two additional extensions of thirty (30) days each to provide the Participant such notification. If the Claims Administrator needs an extension, it will notify the Participant before the expiration of the initial 45-day period (or before the expiration of the first 30-day extension period if a second 30-day extension period is needed), state the reason why the extension is needed, and state when it will make its determination.

If the Claims Administrator determines that a Participant is not eligible for benefits, the notice of the claim's denial will be written in a style and manner calculated to be understood by the Participant and be provided in a culturally and linguistically appropriate manner as set forth in Department of Labor Regulation § 2560.503-1(o). The notice of denial will state:

- the specific reason or reasons for the denial;
- specific references to pertinent Plan provisions on which the denial is based;
- a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such material or information is necessary;
- an explanation of the Plan's claims review procedure;
- a discussion of the decision as set forth in Department of Labor Regulation § 2560.503-1(g)(1)(vii)(A); and
- 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.

If an internal rule, protocol, guideline, or other criterion was relied upon in making the denial, the notice of denial will state the rule, protocol, guideline, or other criterion or a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

If the adverse benefit determination is based on a medical necessity, experimental treatment, or similar exclusion or limit, the Participant will receive one of the following:

- An explanation of scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances; or
- A statement that such explanation will be provided free of charge upon request.

The notification will also contain the procedures on how to appeal for reconsideration of the Participant's claim denial decision (including the time limits applicable to such procedures), as well as a statement indicating the Participant's right to file suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA") after a denial of the Participant's claim on final appeal.

D. *Claim Review Procedure.* Any Participant or the representative of a Participant whose claim has been denied will have the right to request a review of the decision made on his or her claim. Such request must:

1. be in writing;

2. be filed within 180 days after date of the written decision;
3. set forth all of the grounds upon which the request for review is based and any facts in support thereof; and
4. set forth any issues or comments, which the Participant deems pertinent to his or her claim.

The Participant or his or her representative may review documents pertinent to his or her claim.

Upon receipt of the timely request for review of the decision, the Claims Administrator will conduct a full and fair review of the Participant's appeal and provide the Participant with a written decision within forty-five (45) days after receipt of the request for review. This review:

1. will look at the claim anew, and without regard to the prior denial;
2. will take into account all comments, documents, records, and other information that you submit relating to the Participant's claim, whether or not such information was submitted or considered in the initial determination of the Participant's claim;
3. will be conducted by an appropriately named individual who neither made the initial determination that is being appealed, nor is the subordinate of the individual who initially denied the Participant's claim;
4. will be rendered in consultation with a Health Care Professional who has appropriate training and expertise in the field of medicine involved in the medical judgment, if the initial claim determination was made in consultation with a Health Care Professional and if the adverse benefit determination is based in whole or in part on a medical judgment; and
5. will be rendered with the consultation of a Health Care Professional who was not the individual consulted during the initial claim determination that is being appealed, nor the subordinate of that individual.

Should additional time be required in which to review the Participant's request, the Participant will be notified, in writing, within a reasonable period not to exceed 45 days from the date the Claims Administrator receives the Participant's appeal, except for situations requiring an extension of time because of matters beyond the control of the Plan. The extension notification sent to the Participant will indicate (i) the special circumstances requiring an extension, and (ii) the date and time by which the Claims Administrator expects to render a determination on review. In no event, however, will the written decision be issued more than ninety (90) days after the request for review is received. The decision of the Claims Administrator on any benefit claim will be final and conclusive upon all persons

A. *Notification of Benefit Determination Upon Review.* If, on review, the Company determines that a claimant is not eligible for benefits, the claimant will be notified in writing.

The notice will include the following:

1. the specific reason or reasons for the denial;
2. reference to the specific Plan provisions on which the denial was based;
3. if the appeal was denied because sufficient information was not provided, a description of the additional information that was needed and an explanation as to why it was needed;
4. if applicable, the rule, guideline, protocol or similar criterion on which the denial was based or a statement that such rules, guidelines, protocols, standards, or similar criteria do not exist;

5. if the denial is based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances or a statement that such explanation will be provided free of charge upon request;
6. a statement that the Participant has the right to request, free of charge, copies of documents, records, and other information relevant to the Participant's claim appeal;
7. a discussion of the decision as set forth in Department of Labor Regulation § 2560.503-1(j)(6)(i); and
8. a statement of the Participant's right to file a lawsuit under Section 502(a) of ERISA, including any Plan limitations period and the calendar date when the limitations period will expire

B. *Medical Examinations.* The Company may require that a Participant applying for benefits submit to an examination by a Physician designated by the Company, for his or her medical opinion as to whether the Participant is disabled so as to meet the eligibility requirements under the Plan for benefits. Re-examinations of a Participant receiving benefits may be directed by the Company as often as is reasonably necessary for the Company to determine whether continued eligibility for such benefits exists. The fees of such Physician and the expenses of such examination will be paid by the Plan.

C. *Assignment or Transfer of Benefits.* To the maximum extent permitted by law, no benefit payable at any time under the Plan may be assigned or transferable, or subject to any lien, in whole or in part, either directly or by operation of law or otherwise, including, but not limited to, execution, levy, garnishment, attachment, pledge, bankruptcy, or in any other manner. No benefit payable under the Plan will be liable for, or be subject to, any obligation or liability of any Participant.

D. *Payment to Representative.* In the event that a guardian, conservator, committee or other legal representative has been duly appointed for a Participant entitled to any payment under the Plan, any such payment due may be made to the legal representative making claim therefor. Any such payment so made will be in complete discharge of the liabilities of the Plan therefor, and the obligations of the Company and the Company.

VI. COST OF COVERAGE

A. *Participant Contributions.* Participants will not be required to make contributions to the Plan.

B. *Company Contributions.* Disability benefit payments and such other costs as are determined necessary to properly maintain and operate the Plan will be paid out of the Company's general assets.

VII. ADMINISTRATION

A. *Duties of the Plan Administrator*. The Company will serve as the "Plan Administrator" and will have, at its discretion, exclusive authority and responsibility for all matters in connection with the operation and administration of the Plan. Specifically, the Plan Administrator will:

1. be responsible for the compilation and maintenance of all records necessary in connection with the Plan;

2. determine eligibility for benefits under the Plan, and compute and authorize the payment of such benefits as they become payable;

3. decide questions relating to the eligibility of Colleagues to become Participants;

4. engage such legal, actuarial, accounting and other professional and clerical services as may be necessary or proper; and

5. interpret this instrument and make and publish such uniform and non-discriminatory rules for administration of the Plan as are not inconsistent with the provisions of this instrument.

B. *Delegation of Duties*. The Company may, from time to time, delegate any of the rights, powers, and duties of the Plan Administrator (including fiduciary responsibilities) with respect to the operation and administration of the Plan to one or more committees, individuals or entities. If the Plan Administrator delegates any rights, powers or duties to any person, such person may from time to time further delegate such rights, powers and duties to any other person. If any right, power or duty is delegated to more than one person, such persons may from time to time allocate among themselves any such right, power or duty. Any allocation or delegation of fiduciary responsibilities under the Plan will be terminable upon such notice as the Plan Administrator, in its sole discretion, deems reasonable and prudent.

C. *Decisions and Rules*. The decisions of the Plan Administrator made in good faith upon any matter within the scope of its authority will be final, but the Plan Administrator at all times in carrying out its decisions will act in a uniform and nondiscriminatory manner.

D. *Fiduciary Duties*. In performing its duties, the Plan Administrator will act solely in the interest of the Participants:

1. for the exclusive purpose of providing benefits to Participants and defraying reasonable expenses of administering the Plan;
2. with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and
3. in accordance with the documents and instruments governing the Plan, insofar as such documents and instruments are consistent with the provisions of ERISA.

VIII. ERISA

Plan Participants have certain rights and protections under ERISA. ERISA provides that Plan Participants are entitled to:

A. *Receive Information About Your Plan and Benefits*

Examine all benefit plan documents without charge. These documents, including insurance contracts and collective bargaining agreements, are available for inspection at the Plan Administrator's office and at other specified locations. Copies of all documents filed with the U.S. Department of Labor, such as annual reports (Form 5500 Series) and Plan descriptions, are also available for review at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration).

Obtain copies of all Plan documents and other documents and information relating to the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description (SPD). The Plan Administrator may charge a reasonable fee for these copies.

Receive a summary of the Plan's annual financial reports. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

B. *Prudent Actions by Fiduciaries*

In addition to creating rights for Plan Participants ERISA imposes duties on those who are responsible for the operation of the Plan. These people called "fiduciaries" have a duty to operate the Plan prudently and in the best interest of you and other Plan Participants and beneficiaries. Fiduciaries who violate ERISA may be removed and required to make good on losses they have caused the Plan.

No one, including your employer or any other person, may fire or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

C. *Enforce Your Rights*

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

D. *Assistance with Your Questions*

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

IX. MISCELLANEOUS

A. *Permanence of the Plan.* The Company intends to continue the Plan indefinitely, but will not be under any obligation or liability whatsoever to continue to maintain the Plan for any given length

of time. The Company may, in its sole discretion, terminate the Plan any time without any liability whatsoever for such action. If the Plan is terminated, the termination will not affect the rights of any Participant to claim benefits with respect to a Disability incurred prior to such termination.

B. *Right to Amend.* The Company reserves the power and right, at any time or times to amend any or all of the provisions of the Plan to any extent and in any manner it will deem advisable.

C. *No Guarantee of Employment.* The adoption and maintenance of the Plan will not be considered to be a contract between the Company and any Colleague. Therefore, no provision of the Plan will give any Colleague the right to be retained in the employ of the Company or to interfere with the right of the Company to discharge any Colleague at any time, irrespective of the effect such discharge may have upon an Colleagueas a Participant or prospective Participant under the Plan. In addition, no provision of the Plan will be considered to give the Company the right to require any Colleague to remain in its employ, or to interfere with any Colleague's right to terminate his or her employment at any time.

D. *Governing Law.* The Plan will be construed, administered and governed in all respects in accordance with laws of the state of Tennessee except to the extent preempted by the Employee Retirement Income Security Act of 1974, as amended. If any provision of this Plan will be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions of the Plan will continue to be fully effective.

E. *Titles.* Titles are for reference only. In the event of a conflict between a title and the content of a Section, the content will control.

F. *Gender and Number.* Wherever used in this Plan, the masculine gender will include the feminine gender and the singular will include the plural, unless the context indicates otherwise.

G. *Plan Description*. Appendix A to the Plan, is incorporated herein by reference, and includes additional important Plan information.

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Signature Page Rentokil North America, Inc. Short-Term Disability Plan

IN WITNESS WHEREOF, Rentokil North America, Inc. has caused this Plan document to be adopted effective as of January 1, 2024 .

Rentokil North America, Inc.

By: Jennifer M. Owens

Title: Director, Benefits

Date: 5/8/2024

APPENDIX A

TO THE

Rentokil SHORT-TERM DISABILITY PLAN

The following additional information relates to the Plan and is required to be provided pursuant to the Employee Retirement Income Security Act (ERISA).

Formal Plan Name:	Rentokil North America, Inc. Short-Term Disability Plan. This Plan is a component sub-plan under Rentokil North America, Inc Health and Welfare Benefit Plan.
ERISA Plan Number:	501
Type of Plan:	Welfare benefit plan
Plan Year:	Calendar Year
Plan Sponsor:	Rentokil North America, Inc. 1125 Berkshire Blvd Reading, PA 19610 610-372-9700
Plan Sponsor Tax Identification Number:	23-1568350
Affiliated Employers:	Listed in Rentokil North America, Inc. Health and Welfare Benefit Plan & Summary Plan Description Affiliated Employer Appendix
Plan Administrator and Named Fiduciary:	Rentokil North America, Inc. 1125 Berkshire Blvd Reading, PA 19610 610-372-9700
Claims Administrator:	AbsenceOne
Sources of Contributions:	Employer Contributions
Type of Administration:	Benefits under the Short Term Disability Plan are provided on a self-insured basis, meaning benefits are paid from the general assets of the Company rather than an insurance contract. AbsenceOne serves the third-party claims administrator.
Agent for Legal Process:	Service of legal process may be made upon the Plan Administrator.