Samuel, Son & Co. (USA), Inc.
Employee Welfare Benefits Plan

Plan Document and
Summary Plan Description

Effective Date: January 1, 2022

Samuel, Son & Co. (USA), Inc.

Samuel, Son & Co. (USA), Inc. Employee Welfare Benefits Plan
Plan Document and Summary Plan Description

This document incorporates by reference one or more specific contracts or documents that describe in more detail certain provisions governing the Employer Welfare Benefits Plan Document and Summary Plan Description.

PREAMBLE AND EXECUTION

WHEREAS, Samuel, Son & Co. (USA), Inc. ("the Company") maintains the Samuel, Son & Co. (USA), Inc. Employee Welfare Benefits Plan, Plan Document and Summary Plan Description; and

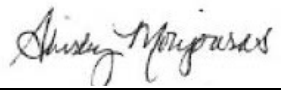
WHEREAS the Company desires to establish the Plan;

NOW, THEREFORE by virtue and in exercise of the power reserved to the Company, the Samuel, Son & Co. (USA), Inc. Employee Welfare Benefits Plan ("the Plan") is hereby established as one Employee Benefit Plan Document and Summary Plan Description, which shall be effective January 1, 2022.

This Plan is maintained pursuant to one or more collective bargaining agreements. A copy of the agreement(s) may be obtained by Covered Persons and beneficiaries upon written request to the Plan Administrator, and is also available for examination by Covered Persons and beneficiaries in the Plan Administrator's principal office.

IN WITNESS WHEREOF, the undersigned has caused the Plan to be executed by its duly authorized officer this 14th day of May 2024.

SAMUEL, SON & CO. (USA), INC.
EMPLOYEE WELFARE BENEFITS PLAN

By: 

Name: Shirley Moujouros

Date: 5/14/2022

Title: Head of Health & Retirement Plans - USA

ESTABLISHMENT OF PLAN; GENERAL PLAN INFORMATION

Effective Date

The Effective Date (as defined herein) of the Samuel, Son & Co. (USA), Inc. Employee Welfare Benefits Plan ("the Plan") is January 1, 2020**.**

Purpose

Samuel, Son & Co. (USA), Inc. (the "Company") maintains the Plan for the exclusive benefits of its eligible employees and their eligible Dependents. The purpose of the Plan is to consolidate in one plan document and summary plan description certain provisions of the multiple welfare benefit plans (the "Component Benefit Plans") sponsored by the Company and to provide uniform administration of such welfare benefits. The Component Benefit Plans are listed in Appendix A to this Plan.

This document is not the only document comprising the Plan. Rather, the entire Plan document is a series of documents consisting of this document plus the various insurance contracts, summary plan descriptions, certificates of coverage, policies and procedures, internal guidelines of carriers and administrators, enrollment materials, and any other documents providing substantive terms and conditions for the various benefits offered under the Plan ("Component Benefit Plan Documents"). These Component Benefit Plan Documents are incorporated into this document by reference, as if fully stated herein. Therefore, this document and the Component Benefit Plan Documents in the aggregate serve as a written plan document for the purposes of compliance with Section 402 and the Summary Plan Description as required by Section 102 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). These documents should read together and kept together. Eligible employees may obtain an additional copy of any Component Benefit Plan Documents upon written request at no charge. Including Component Benefit Plans that are not subject to ERISA as part of this Plan is not intended to subject such Component Benefit Plans to ERISA.

Duration

The Plan is established with the intention of being maintained for an indefinite period of time; however, the Company, as defined within the Definitions Section, in its sole discretion and in accordance with the provisions herein may at any time amend or terminate the Plan or any provision of the Plan including, but not limited to, the existence and duration of coverage for Employees and/or Dependents of Employees, eligibility and requirements for coverage, the availability, nature and extent of benefits, and the conditions for and method of payment of benefits.

General Information about the Plan

Name of Plan:
Samuel, Son & Co. (USA), Inc. Employee Welfare Benefits Plan

Plan Sponsor:
Samuel, Son & Co. (USA), Inc.
251 Little Falls Drive
Wilmington, DE 19808
Phone: 630-783-8900
Website: www.samuel.com

Plan Administrator:
(Named Fiduciary)
Samuel, Son & Co. (USA), Inc.
251 Little Falls Drive
Wilmington, DE 19808
Phone: 630-783-8900
Website: www.samuel.com

Plan Sponsor ID No. (EIN):
06-1251791

Plan Year:
January 1 through December 31

Effective Date:
January 1, 2020

Plan Number:
516

Type of Plan:
Employee benefits plan providing group:
Medical and Prescription Drug
Dental
Vision
Basic Life / Accidental Death and Dismemberment
Short Term Disability
Long Term Disability
Critical Illness
Accident
Hospital Indemnity
Cafeteria Plan

Non-English Language Notice:
This Plan Document contains a summary in English of a Covered Person's plan rights and benefits under the Plan. If a Covered Person has difficulty understanding any part of this Plan Document, he or she may contact the Plan Administrator at the contact information above.

Funding Medium and Type of Plan Administration:
Benefits are provided through group insurance policies or group health plans issued to the Company.

The Medical and Prescription Drug benefits are self-insured and administered by Highmark Blue Cross Blue Shield. Both the Company and the participating Employees contribute to the Medical and Prescription Drug benefits.

The Dental benefits are self-insured and administered by United Concordia Insurance Company. Both the Company and the participating Employees contribute to the Dental benefits.

The Vision benefits are self-insured and administered by Highmark Blue Cross Blue Shield. Both the Company and the participating Employees contribute to the Vision benefits.

The Basic Life / Accidental Death and Dismemberment benefits are fully insured and administered by MetLife. The Company contributes to the premiums.

The Short Term Disability benefits are fully insured and administered by MetLife. The Company contributes to the premiums (The participating Employees contribute to the premiums in the Tubular Union plan).

The Long Term Disability benefits are fully insured and administered by MetLife. The Company contributes to the premiums. (The participating Employees contribute to the premiums in the Tubular Union plan).

The Voluntary Critical Illness, Accident and Hospital Indemnity benefits are fully insured and administered by MetLife. The participating Employees contribute to the premiums.

The Employer Paid Critical Illness and Accident benefits are fully insured and administered by MetLife. The Company contributes to the premiums.

The Cafeteria Plan benefits are administered by Highmark Blue Cross Blue Shield. The Cafeteria Plan (attached as Appendix C) is intended to qualify under Section 125 of the Internal Revenue Code of 1986, as amended. Participating Employees contribute to these benefits as provided in this Plan, the Cafeteria Plan and in the applicable Component Benefit Plan(s), in accordance with applicable law.

The Company administers the Plan and the availability of group insurance and health plans to fund the benefits. The Company shares some responsibility with the insurance companies and third party administrators for administering group insurance policies and health plans as described in the Administration Section. Premiums and contributions paid for by the Company come out of its general assets. Premiums and contributions paid by eligible participating employees are paid in part by pre-tax or post-tax payroll deductions. The Plan Administrator provides the employees a schedule of the applicable premiums and contributions during the initial and subsequent open enrollment periods and on written request for each Component Benefit Plan as applicable.

Insurance Companies and/or Administrators:
Please refer to Appendix A for a list of all carriers and/or administrators.

Participating Employer(s):
Samuel, Son & Co. (USA), Inc.
1401 Davey Road, suite 300
Woodridge, IL 60517
Phone:630-783-8900

Agent *(for service of process)*:
Samuel, Son & Co. (USA), Inc.
Head of Health and Retirement - USA
1401 Davey Road, suite 300
Woodridge, IL 60517
Phone:630-783-8900
Website: www.samuel.com

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Important Disclaimer: All benefits under the Plan are provided through Component Benefit Plan Documents. If the terms of this document conflict with the terms of such Component Benefit Plan Documents, the terms of the Component Benefit Plan Documents will control, unless otherwise required by law.

DEFINITIONS

The following words and phrases, when capitalized, shall have the following meanings. Words and phrases not defined in this Section shall have the meaning set forth in an applicable Component Benefit Plan, and if not defined in an applicable Component Benefit Plan, then such words and phrases shall have the meaning customarily given them by the applicable insurance company, third party administrator, or other service provider, as the case may be.

AD&D
AD&D means accidental death and dismemberment insurance.

Cafeteria Plan
A Cafeteria Plan is a type of tax-advantaged employee benefits program created under Code Section 125 that allows Employees to pay certain qualified expenses on a pre-tax basis.

Claimants
A Covered Person (or his or her duly authorized representative) may file a claim for benefits to which such Claimant believes he or she is entitled.

COBRA
COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X), as amended, and the regulations issued thereunder. COBRA applies only to the following benefits provided under this Plan:

Medical and Prescription Drug
Dental
Vision

Code
Code means the Internal Revenue Code of 1986, as amended, and its regulations.

Company
Company means Samuel, Son & Co. (USA), Inc., and any successor, by merger or otherwise.

Component Benefit Plans
Component Benefit Plans means the specific benefit arrangement(s) identified in Appendix A pursuant to which the Plan provides welfare benefits.

Component Benefit Plan Documents
Component Benefit Plan Documents means an insurance policy or contract, administrative services agreement, plan, trust, certificate of coverage, evidence of coverage, summary plan description, policies and procedures, internal guidelines of carriers and administrators, enrollment materials, and any other documents making up the Component Benefit Plans that contain the substantive provisions governing the Component Benefit Plans, together with any exhibits, supplements, addendums or amendments thereto.

Covered Person
Covered Person means an individual who has properly enrolled in, and who participates in a Component Benefit Plan in accordance with the terms and conditions established for that benefit plan, and who has not for any reason become ineligible to participate further in that benefit plan. Participation requirements are described in the applicable Component Benefit Plan Documents.

Dependent
Dependent means a spouse or dependent child of an Employee who is a Covered Person who is eligible to participate in the Plan pursuant to the terms of one or more Component Benefit Plans, and who is a "dependent" within the meaning of Section 152, as modified for purposes of Code Sections 105(b) and 106.

A Dependent may be eligible for coverage with respect to certain benefits, but not all benefits, as hereinafter described in the Plan.

Dependent Care Assistance Program (DCAP)
Dependent Care Assistance Program (DCAP) means a benefit that allows Employees to use pre-tax dollars to pay for the care of eligible Dependents while Employees are at work. The DCAP is part of a Component Benefit Plan under this Plan and is established by the Company under a separate document.

Effective Date
Effective Date means the date this Plan becomes operative; the Effective Date is January 1, 2020. The effective date of each Component Benefit Plan is set forth in the applicable Component Benefit Plan Documents.

Employee
Employee means a common law employee of an Employer. The term Employee does not mean any of the following persons:

1. A self-employed individual, as defined in Code Section 401(c)(1)(A),
2. A member of the board of directors of the Company who is not otherwise an Employee,
3. A person the Plan Administrator determines is an Employer's independent contractor, or
4. A person the Plan Administrator determines an Employer engages as a consultant or advisor on a retainer or fee basis.

Any person the Plan Administrator determines is not an "Employee" as defined above shall not be eligible to participate in the Plan regardless of whether such determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters. If any such person is later determined by the Plan Administrator or by a court or governmental agency to be an Employee or to have been an Employee, he or she will only be eligible for Plan participation prospectively following such determination and after the satisfaction of all other eligibility requirements.

Employer
Employer means the Company and any subsidiary and any successor which, with the approval of the Plan Administrator, and subject to such conditions as the Plan Administrator may impose, adopts the Plan.

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

Health Flexible Spending Arrangement (Health FSA)
Health Flexible Spending Arrangement (Health FSA) means a benefit plan that allows Employees to use pre-tax dollars to pay for certain medical and dental expenses not reimbursed under other programs. The Health FSA is a Component Benefit Plan under this Plan and is established by the Company under a separate document.

Health Savings Account (HSA)
Health Savings Account (HSA) means a health savings account within the meaning of Section 223 of the Code. The HAS is a Component Benefit Plan under this Plan and is established by the Company under a separate document. The HSA is not subject to ERISA.

HIPAA
HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended, and regulations issued pursuant thereto.

Plan
Plan means the Samuel, Son & Co. (USA), Inc. Employee Welfare Benefits Plan as herein set forth and as amended from time to time.

Plan Administrator
Plan Administrator means the person(s) authorized and responsible for managing and directing the operation and administration of the Plan.

Plan Year
Plan Year means the 12-month period beginning January 1 and ending December 31. The Plan Year for each Component Benefit Plan is set forth in the applicable Component Benefit Plan document.

ELIGIBILITY, PARTICIPATION, AND COVERAGE

Eligibility

Generally, the following provides the description of eligible Employees for Plan participation: Regular Employees (excludes Temporary workers) in the U.S. scheduled to work 30 or more hours per week; the plan also excludes employees who are members of the U.S. Teamsters Union. While information regarding eligibility in this section is generally correct, in the event of a conflict with a Component Benefit Plan's eligibility requirements, the terms of the Component Benefit Plan will control, unless otherwise required by law.

Effective Date of coverage:

Benefit program	Wait period	Example
Harmony Benefits Program (Salaried and non-union hourly)	First of next month following date of hire	Hired on April 1 or April 30, eligible on May 1
Steel Fab Union (US Boilermakers)	1st of the month following completion of 60 days of employment	Hired on August 1 or August 2, eligible October 1
Tubular Union (US Retail Wholesale Workers)	Completion of union 90 days probationary period	(91st day of employment)
Missouri Metals Union (US Aerospace Workers)	1st of the month following completion of 60 days of employment	Hired on August 1 or August 2, eligible October 1

Note that certain Component Benefits Plans may require that you make an annual election to enroll for coverage. Information relative to enrollment procedures was distributed upon your eligibility to participate. An individual may request a copy of the Component Benefit Plan Documents at no charge.

Medical Plan Opt-out Incentive – Employees eligible for the Harmony Benefits Program and the Steel Fab Union Program are eligible for an annual Medical Plan opt-out incentive, $2,000 and $1,000, respectively. To receive the incentive, employees must actively enroll in the Opt-out Incentive Option annually during Open Enrollment or following Qualified Life Events. The incentive is paid quarterly, following the end of each quarter in which the Opt-out Incentive was elected for the entire previous quarter. Employees must be actively employed at time of payment.

HSA Employer Contributions – The Company provides an annual contribution to Employees' Health Savings Accounts for employees who are eligible for the Harmony Benefit Program and the Steel Fab Union Program. The below annual amounts are paid semi-annually, in January and July to employees who elect the High Deductible Health Plan of January 1 and July 1, respectively. Employees must be active at time of payment

Annual Company HSA Contributions	
Employee Only:	$500
Employee plus One Dependent:	$750
Family:	$1,000

Participation

The provisions and requirements describing how and when Employees become Covered Persons in the Plan and any conditions and limitations to participation in the Plan shall be as set forth in the applicable Component Benefit Plan Documents.

Coverage

The provisions and requirements describing when and how Employees and Dependents become Covered Persons, the conditions and limitations to coverage, and the circumstances under which coverage terminates shall be as set forth in the applicable Component Benefit Documents.

Termination

Your participation and the participation of your eligible family members in the Plan will terminate with your termination of employment. Your employment generally ends when you cease active work with the Company. Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below any required hourly threshold, if you submit false claims or for any other reason set forth in the applicable Component Benefit Plan Documents. Child dependents generally lose coverage on the day they age out of the Component Benefit Plan.

Coverage under Family and Medical Leave Act and Section 609 of ERISA

Family and Medical Leave Act of 1993

If not otherwise provided for herein, the Plan shall provide coverage for a Covered Person who is an Employee solely to the extent necessary to comply with the Family and Medical Leave Act of 1993 ("FMLA"), and the Plan shall be interpreted and administered as necessary to comply with FMLA and the rulings and regulations issued thereunder.

Section 609 of ERISA

If not otherwise provided for herein, the Plan shall provide coverage to a child solely to the extent required by a qualified medical child support order under Section 609(a) of ERISA or to an adoptive child or child placed for adoption solely to the extent required by Section 609(c) of ERISA. Further, the Plan shall be interpreted and administered as necessary to comply with Section 609 of ERISA and the rulings and regulations issued thereunder.

Coverage Contingent Upon Contribution

Any coverage provided as a result of this Section shall be conditioned upon payment of applicable contributions by the Employee.

Uniformed Services Employment and Reemployment Rights Act

Solely to the extent required by the Uniformed Services Employment and Reemployment Rights Act (hereinafter the "Uniformed Services Act"), a Covered Person who is an Employee who enters military service shall have the right to continue coverage under the Plan for the period prescribed under the Uniformed Services Act. Continuation of coverage shall be conditioned upon payment of any required premiums.

This Section shall be interpreted and applied to give an Employee only those rights as are prescribed under the Uniformed Services Act and rulings and regulations issued thereunder.

Health Insurance Portability and Accountability Act of 1996

HIPAA Title I

Solely to the extent required by the Health Insurance Portability and Accountability Act of 1996 (hereinafter "HIPAA"), an Employee shall be a Covered Person under the Plan no later than such time as required under HIPAA, and the Plan shall be subject to the special enrollment and nondiscrimination in health status provisions of HIPAA. This Section shall be interpreted and applied to give an Employee only those rights as prescribed under HIPAA and the rulings and regulations issued thereunder.

HIPAA Title II

The Plan shall comply with the privacy and security regulations of HIPAA, in accordance with the provisions set forth in HIPAA Privacy and HIPAA Security Sections. This Section shall be interpreted and applied to give an Employee only those rights as prescribed under the Health Insurance Portability and Accountability Act of 1996, and the rulings and regulations issued thereunder.

Coordination with State Medicaid Programs

The fact that a Covered Person is eligible for coverage by, or is covered by, a State Medicaid program shall not affect the Covered Person's eligibility to participate in the Plan or to receive benefits. The payment of

benefits under the Plan with respect to any Covered Person shall be made in accordance with any assignment of rights made by or on behalf of the Covered Person of a beneficiary of the Covered Person as required by any State Medicaid program, as provided in Section 609(b) of ERISA. To the extent a payment has been made to or with respect to a Covered Person pursuant to a State Medicaid program and the amount so paid is for a medical expense that the Plan has a legal liability to pay, the Plan will pay such expense in accordance with any State law that provides that the State has acquired the right with respect to the Covered Person to receive payment for such expense.

This Section shall be interpreted and applied to give an Employee only those rights as prescribed under State Medicaid Programs, and the rulings and regulations issued thereunder.

Mental Health Parity Act and Mental Health Parity and Addiction Equity Act

Pursuant to the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations to the extent required. For further details, please contact the Plan Administrator.

Women's Health and Cancer Rights Act

Solely to the extent required under the law of the Women's Health and Cancer Rights Act (hereinafter "WHCRA"), the Plan shall provide certain benefits related to benefits received in connection with a mastectomy.

In the case of a Covered Person who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the coverage shall be provided in a manner determined in consultation with the attending physician and the patient for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Such reconstructive benefits are subject to annual plan deductibles and coinsurance provisions such as other medical and surgical benefits covered under the Plan.

This Section shall be interpreted and applied to give an Employee only those rights as prescribed under WHCRA, and the rulings and regulations issued thereunder.

Newborns' and Mothers' Health Protection Act

Solely to the extent required by the Newborns' and Mothers' Health Protection Act (hereinafter "NMHPA"), the Plan shall provide that coverage for childbirth may not be limited to a hospital stay of less than 48 hours for normal delivery, or less than 96 hours for cesarean section, or require the provider to obtain approval for shorter hospital stays. The requirement shall not apply if the attending provider, in consultation with the mother, decides to discharge the mother or newborn earlier than the time prescribed by the NMHPA.

This Section shall be interpreted and applied to give Covered Persons only those rights as prescribed under the NMHPA, and the rulings and regulations issued thereunder.

Genetic Information Nondiscrimination Act of 2008

The Plan shall also comply with the Genetic Information Nondiscrimination Act of 2008 (hereinafter "GINA").

This Section shall be interpreted and applied to give Covered Persons only those rights as prescribed under GINA, and the rulings and regulations issued thereunder.

Children's Health Insurance Program Reauthorization Act of 2009

The Plan shall also comply with the Children's Health Insurance Program Reauthorization Act of 2009 (hereinafter "CHIP").

This Section shall be interpreted and applied to give Covered Persons only those rights as prescribed under CHIP, and the rulings and regulations issued thereunder.

Michelle's Law

The Plan shall also comply with Michelle's Law (P.L. 110-381).

This Section shall be interpreted and applied to give Covered Persons only those rights as prescribed under Michelle's Law, and the rulings and regulations issued thereunder.

BENEFITS

Medical and Prescription Drug Benefits

Covered Persons shall have the right to the medical benefits and prescription drug benefits described in the applicable Component Benefit Plan Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Component Benefit Plan Documents. A description of such benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan Documents.

Dental Benefits

Covered Persons shall have the right to the dental benefits described in the applicable Component Benefit Plan Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Component Benefit Plan Documents. A description of such benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan Documents.

Vision Benefits

Covered Persons shall have the right to the vision benefits described in the applicable Component Benefit Plan. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Component Benefit Plan Documents. A description of such benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan Documents.

Basic Life / Accidental Death and Dismemberment Benefits

Covered Persons who are Employees, shall have the right to the Basic Life / Accidental Death and Dismemberment Benefits described in the applicable Component Benefit Plan Documents. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Component Benefit Plan Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions, the procedure for naming beneficiaries and consequences for failure to name a beneficiary, shall be as set forth in the applicable Component Benefit Plan Documents.

Short Term Disability Benefits

Covered Persons who are Employees shall have the right to the short term disability insurance benefits described in the applicable Component Benefit Plan Documents. Such benefits shall be subject to the terms, conditions and limitations set forth in such Component Benefit Plan Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan Documents.

Long Term Disability Benefits

Covered Persons who are Employees shall have the right to the long term disability insurance benefits described in the applicable Component Benefit Plan Documents. Such benefits shall be subject to the terms, conditions and limitations set forth in such Component Benefit Plan Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan Documents.

Critical Illness Benefits

Covered Persons who are Employees shall have the right to the critical illness benefits described in the applicable Component Benefit Plan Documents. Such benefits shall be subject to the terms, conditions and limitations set forth in such Component Benefit Plan Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan Documents.

Accident Benefits

Covered Persons who are Employees shall have the right to the accident benefits described in the applicable Component Benefit Plan Documents. Such benefits shall be subject to the terms, conditions and limitations set forth in such Component Benefit Plan Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan Documents.

Hospital Indemnity Benefits

Covered Persons who are Employees shall have the right to the hospital indemnity benefits described in the applicable Component Benefit Plan Documents. Such benefits shall be subject to the terms, conditions and limitations set forth in such Component Benefit Plan Documents. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan Documents.

Cafeteria Plan Benefits

While the Cafeteria Plan is not subject to this Plan, the benefits offered by the Cafeteria Plan are Component Benefit Plans under this Plan. Covered Persons shall have the right to the benefits described below and in the Cafeteria Plan and the applicable Component Benefit Plan Documents. Such benefits shall be subject to the terms, conditions and limitations set forth in such Component Benefit Plan Documents and the Cafeteria Plan. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan Documents. The Company sponsors the Samuel, Son & Co. (USA), Inc. Cafeteria Plan which is intended to qualify under Section 125 of the Internal Revenue Code of 1986, as amended (the "Code"), and which is attached as Appendix C.

The following benefits are available under the Samuel, Son & Co. (USA), Inc. Cafeteria Plan:

Health FSA
DCAP (not subject to ERISA)
HSA (not subject to ERISA)

COORDINATION OF BENEFITS

Coordination of Benefits Provisions

Coordination of benefits provisions are set forth in Component Benefit Plan Documents where applicable. For more information regarding coordination of benefits, see the applicable Component Benefit Plan Documents.

CONTINUATION COVERAGE

Continuation Coverage

Continuation coverage provisions are set forth in the Component Benefit Plan Documents where applicable. The following Component Benefit Plan Documents contain continuation coverage information:

Medical and Prescription Drug
Dental
Vision
Health FSA

Certain Employees and Dependents shall have the right to purchase continuation coverage under the Component Benefit Plans in accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, Title X (COBRA), provided such individuals were Covered Persons under the applicable Component Benefit Plan on the date immediately preceding the date of a Qualifying Event or become Covered Persons during the continuation period because such Dependent is born to or placed for adoption with the Employee.

COBRA rights are explained in detail in applicable Component Benefit Plan Documents (insurance booklet, certificate of coverage/policy, or plan document). If you have any questions about your COBRA rights, please contact the Plan Administrator for a copy of your COBRA rights. Your COBRA rights are briefly summarized below.

Continuation Coverage Definitions.
For purposes of this Section, the following terms have the following meanings:

A. "Employee" means a person who is (or was) covered under the Plan by virtue of the person's performing services for the Employer on the day before the occurrence of the event giving rise to the right to elect COBRA continuation coverage.

B. "Dependent" means, with respect to an Employee as defined in this Section, any individual who, on the day before the occurrence of the event giving rise to the right to elect COBRA continuation coverage, is covered under the Plan as (1) the Dependent spouse of such Employee or (2) the Dependent child of such Employee. The term Dependent shall include any child born to or placed for adoption with the Employee during the continuation period.

C. "Qualified Beneficiary" means an Employee or Dependent as defined in this Section but shall not mean Dependents defined in the Election Rules, except that the term Qualified Beneficiary shall include Dependents born to or placed for adoption with the Employee during the continuation period.

D. "Qualifying Event" means any of the following, the occurrence of which would result in loss of coverage under the Plan were it not for the right to purchase COBRA continuation coverage:

1. For Employees, termination of employment for any reason other than gross misconduct, or loss of eligibility due to reduction in hours worked by the Employee.

2. For Dependents:
   a. Death of the Employee.
   b. Divorce of the Employee and spouse.
   c. Legal separation of the Employee and spouse.
   d. Reduction in hours worked by the Employee or termination of employment by the Employee for any reason other than gross misconduct.
   e. Entitlement of the Employee to benefits under Title XVIII of the Social Security

Act (relating to Medicare).

f. Ceasing to qualify as a Dependent child under the Plan.

The Qualifying Event shall be deemed to occur on the date of the Qualifying Event, not on the date coverage ends because of the Qualifying Event.

Loss of Eligibility for Continuation Coverage.

A Qualified Beneficiary shall not be eligible for COBRA continuation coverage unless both A and B occur:

A. The Company or Plan Administrator is notified of the election of COBRA continuation coverage, on a form provided for that purpose, within 60 days of the later of:

1. The date the Qualified Beneficiary's coverage under the Plan would otherwise terminate by reason of an event described in this Section.
2. The date notice of eligibility is sent to the individual in accordance with the Notice Requirements.

B. The Qualified Beneficiary pays the initial required premium, as set forth in the Required Premium Section below, no later than the date 45 days after the date on which COBRA continuation coverage was elected.

Until expiration of the election period, a Qualified Beneficiary may change or revoke any election. Failure to elect COBRA continuation coverage within the prescribed election period shall result in a waiver of the right to COBRA continuation coverage.

Termination of COBRA Continuation Coverage

COBRA continuation coverage shall terminate on the date on which the earliest of the following occurs:

1. The last day of the month preceding the date the Qualified Beneficiary fails to pay a subsequent required premium within 30 days of the date it is due.
2. The date the Qualified Beneficiary first becomes, after the date of making a COBRA election, entitled to (i.e., enrolled in) Medicare.
3. The date the Qualified Beneficiary first becomes, after the date of making a COBRA election, covered under another group health plan, as defined in Code Section 5000(b)(1), not containing a limitation or exclusion as to any preexisting condition of such individual (other than such an exclusion or limitation which does not apply to, or is satisfied by, such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996).
4. 36 months from the date on which a Qualifying Event described in Continuation Coverage Definitions Sections (D)(2)(a), (D)(2)(b), (D)(2)(c), (D)(2)(e), or (D)(2)(f) occurs.
5. 18 months from the date on which a Qualifying Event described in Continuation Coverage Definitions Sections (D)(1) or (D)(2)(d) occurs. If a Qualifying Event described in Continuation Coverage Definitions Sections (D)(2)(a), (D)(2)(b), (D)(2)(c), or (D)(2)(f) occurs subsequent to a Qualifying Event described in Continuation Coverage Definitions Section (D)(2)(d), an additional period of coverage shall be allowed for Dependents who have properly and timely elected and paid for COBRA continuation coverage; but, in no event shall the sum of the first and second periods of coverage exceed 36 months from the date of the first Qualifying Event giving rise to the Qualified Beneficiary's eligibility for COBRA continuation coverage.
6. The date the Company terminates all group health plans.
7. In the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act to have been disabled (i) at the time of the Qualifying Event or (ii) at any time during the first 60 days of continuation coverage, the 18-month period set forth in Termination of COBRA

Continuation Coverage Section (E) shall be extended to 29 months; provided that such individual notifies the Plan Administrator of such determination in accordance with Notice Requirements Section (D) before the end of such 18-month period; and provided further that if the Qualified Beneficiary does not remain disabled during the extended period, coverage shall cease with the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled.

8. In the case of a Qualifying Event described in Continuation Coverage Definitions Section (D)(2)(d) that occurs.

9. less than 18 months after the date the Employee becomes entitled to Medicare, 36 months from the date the Employee becomes entitled to Medicare.

10. For the Health FSA or Limited-Purpose Health FSA, the last day of the Plan Year in which the Qualifying Event occurs.

Notice Requirements.

1. The Employer shall notify the Plan Administrator of the occurrence of an event described in Continuation Coverage Definitions Sections (D)(1), (D)(2)(a), (D)(2)(d), and (D)(2)(e), within 30 days of the date of the described event.

2. The Qualified Beneficiary shall be responsible for notifying the Plan Administrator of the occurrence of an event described in Continuation Coverage Definitions Sections (D)(2)(b), (D)(2)(c), or (D)(2)(f) within 60 days of the date of the described event.

3. The Plan Administrator shall provide notice to Qualified Beneficiaries of their COBRA continuation coverage rights within 14 days of the date it receives the notice described in Notice Requirements Sections (A) and (B).

4. A Qualified Beneficiary, who is determined under Title II or XVI of the Social Security Act to have been disabled at any time within the first 60 days of the continuation period, shall be responsible for notifying the Plan Administrator of such determination within 60 days after the date of such determination, but in no event later than the end of the 18-month period set forth in Termination of COBRA Continuation Coverage Section (E). Such Qualified Beneficiary further shall be responsible for notifying the Plan Administrator of any final determination under such Title(s) that he or she is no longer disabled, within 30 days of the date of such determination.

5. At the commencement of coverage under the Plan, the Plan Administrator shall provide each Employee or spouse who is a Covered Person with notice of their rights under COBRA.

6. The Plan Administrator shall provide notice to each Qualified Beneficiary of any termination of COBRA continuation coverage that takes effect earlier than the end of the maximum period of COBRA continuation coverage applicable to the Qualified Beneficiary.

7. The Plan Administrator shall provide notice to each Employee, spouse or Dependent of the unavailability of COBRA continuation coverage if the Plan Administrator determines after receiving notice of a Qualifying Event that the Employee, spouse or Dependent is not entitled to COBRA continuation coverage.

Coverage Available for Continuation

A Qualified Beneficiary may elect to continue receiving the health care coverage (as defined in COBRA regulations) he or she was receiving immediately before the event giving rise to the right to elect COBRA continuation coverage. If coverage provided to similarly situated active Employees is changed or eliminated, COBRA continuation coverage also shall be changed or eliminated. If the Company terminates the Plan but continues to maintain one or more other group health plans, as defined in Code Section 5000(b)(1), COBRA continuation coverage recipients may elect coverage under one of those other group health plans. A Qualified Beneficiary may elect to continue to receive coverage for the level of reimbursement, if any, that the individual had in effect under his or her Health FSA or Limited-Purpose Health FSA immediately before the Qualifying Event after reflecting debits for health care reimbursements made up to the Qualifying Event.

Election Rules

A. Scope of Election

Each affected Qualified Beneficiary generally shall have an independent right to elect or reject COBRA continuation coverage under this Section; provided, however, that in the event an Employee or his or her spouse makes an election to continue coverage on behalf of the other or on behalf of any other Qualified Beneficiary, such election shall be binding on such other party; and provided further, that in the event the Qualified Beneficiary is a minor or an incapacitated person, the parent or legal guardian of such minor or the legal representative of such incapacitated person shall have the right to elect or reject continuation coverage on behalf of such minor or incapacitated person, and any such election or rejection of coverage shall be binding on such minor or incapacitated person. Each Qualified Beneficiary is entitled to a separate election with respect to any choice of coverages available under the Plan.

D. After Acquired Dependents

A Qualified Beneficiary eligible for COBRA continuation coverage may elect to cover Dependents (as defined in this Section) acquired after the date of eligibility described under the Loss of Eligibility of Continuation Coverage Section to the same extent as Covered Persons, provided the Company or Plan Administrator is notified of the election to cover such Dependent(s) in the manner and within the time set forth in an applicable document incorporated by reference under the Plan, except that in no event shall notice be required within a period of less than 30 days. Such newly acquired Dependent(s), other than Qualified Beneficiaries defined in this Section, shall have no independent right to COBRA continuation coverage. Failure to notify the Company or Plan Administrator within the prescribed time shall result in a waiver of the right to elect COBRA continuation coverage for such newly acquired Dependent(s).

C. Open Enrollment Periods

During an open enrollment period occurring during the COBRA coverage period, a Qualified Beneficiary may elect to cover Dependents not previously covered, subject to the terms and conditions set forth in the applicable document incorporated by reference under the Plan. This subsection (C) shall not apply to Health FSA or Limited-Purpose Health FSA benefits.

Required Premium.

In order to receive COBRA continuation coverage, Qualified Beneficiaries shall agree, on forms furnished by the Plan Administrator, to pay any required premiums to the Plan and shall make such premium payments when and as required. All premiums other than the initial premium shall be due on the first day of the calendar month. The amount of the premium shall be no more than 102 percent of the cost of coverage. In the case of a Qualified Beneficiary who is determined under Title I or XVI of the Social Security Act to have been disabled at any time within the first 60 days of continuation coverage, the cost of coverage for the 19th month through the 29th month of coverage shall be no more than 150 percent of the cost of coverage. Notwithstanding the foregoing, the cost of coverage shall not exceed the maximum, nor be changed more frequently than, permitted by law.

Governing Provisions.

When the provisions for COBRA continuation coverage are set forth in an applicable Component Benefit Plan Document, such applicable Component Benefit Plan Document shall govern except to the extent such language fails to comply with requirements of applicable law or fails to determine the right or liability of the party, in which case the provisions of this Section shall govern.

CONTRIBUTIONS, FUNDING AND PLAN ASSETS

Contributions

Employer Contributions

The Employer shall pay, as contributions to the Plan, all or a portion, as determined by the Company, of the cost of the benefits provided under the Plan. The Employer reserves the right to cease payments under the Plan at any time and shall be under no obligation to make any contributions to the Plan after the Plan is terminated.

Employee Contributions

1. **Amount:** From time to time, the Company shall determine, on a fixed dollar or percentage basis, the amount, if any, of contributions required from Covered Persons who are Employees to entitle them and their Dependents, if applicable, to be covered by and receive benefits under the Plan. The amount of such contribution shall be as set forth in any election or enrollment materials, whether paper or electronic as part of a web-based enrollment process, issued or posted in conjunction with the Plan or the Company's Cafeteria Plan (if applicable), as such materials may be changed from time to time. Any such election or enrollment materials are hereby incorporated by reference into the Plan as if set forth in full herein. Employee contributions under the Company's Cafeteria Plan (if applicable) are subject to maximum contribution limits as established by the Company and in compliance with Internal Revenue Service contribution limitations.
2. **Payment:** As a condition of receiving benefits under the Plan, eligible Employees shall agree, on forms or materials furnished by the Company or through a telephone or web-based enrollment process, to make contributions under the Plan in the amount determined as described above and shall make such contributions when and as required. If so, provided under the terms of the Company's Cafeteria Plan contributions by Employees shall be made by salary reduction in accordance with the terms of such plan and a corresponding contribution by the Employer.

Priority of Contributions

Benefits shall be deemed to come first from amounts contributed by eligible Employees and then from amounts contributed by the Employer.

Funding

Funding Policy

The Company shall establish and carry out, and may revise from time to time, the funding policy for the Plan.

Funding Mechanism

Contributions from the Employer and/or eligible Employees may be held under or paid to one or more of the following vehicles: insurance policies or arrangements, Health Maintenance Organizations or dedicated trust funds established by the Employer. In addition, benefits may be paid directly from the general assets of the Employer.

Plan Assets

Subject, in all cases, to the right of the Employer to terminate its obligation hereunder, the Employer shall pay benefit(s) provided for herein, to the extent not:

1. Provided for by Employee contributions.
2. Payable from an insurance policy held under the Plan.
3. Paid by a dedicated trust fund established by the Employer.

Where an insurance policy provides for payment of premiums directly from the Company, unless the insurance policy states otherwise, payable dividends, retroactive rate adjustments, or experience refunds are not Plan Assets. These dividends, retroactive rate adjustments, or experience refunds are Company property, which the Company may retain to the extent they do not exceed the Company's aggregate contributions to Plan cost made from its own funds.

ADMINISTRATION

Plan Administrator

The Company shall appoint a person, entity or committee to serve as Plan Administrator. In the absence of such appointment, the Company shall be the Plan Administrator. The Plan Administrator shall be the "named fiduciary" for purposes of ERISA.

Plan Administrator's Duties

Except as to those functions reserved within the Plan to the Board of Directors, the Company, or an Employer, the Plan Administrator shall have the duty to manage the operation and administration of the Plan. The Plan Administrator shall cause to be maintained such records as may be reasonably necessary or desirable for the proper management and administration of the Plan. The Plan Administrator shall also cause to be maintained for inspection by any individual who participates or is eligible to participate in the Plan, a copy of the document governing the Plan; the latest annual report, summary annual report, and summary plan description; and any amendments or changes to these documents. Upon written request, the Plan Administrator shall provide to such participating or eligible individuals a copy of these documents and may impose a reasonable charge, as permitted by law, for such copies.

Plan Administrator's Powers

Except as expressly limited or reserved in the Plan to the Board of Directors, the Company or an Employer, the Plan Administrator shall have the right to exercise, in a uniform and nondiscriminatory manner, full discretion with respect to the administration, operation, and interpretation of the Plan. Without limiting the generality of the foregoing rights, the Plan Administrator shall have full power and discretionary authority to:

1. Require any person to furnish such information as the Plan Administrator may request from time to time and as often as the Plan Administrator determines reasonably necessary for the purpose of proper administration of the Plan and as a condition to the individual's receiving benefits under the Plan.
2. Make and enforce such rules and prescribe the use of such forms as the Plan Administrator determines reasonably necessary for the proper administration of the Plan.
3. Interpret the Plan and decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions.
4. Determine all questions concerning the eligibility of any individual to participate in, be covered by, and receive benefits under the Plan pursuant to the provisions of the Plan.
5. Determine whether objective criteria set forth in the Plan have been satisfied respecting any term, condition, limitation, exclusion, and restriction or waiver thereof.
6. Delegate to other person(s) any duty that otherwise would be a fiduciary responsibility of the Plan Administrator under the terms of the Plan.
7. Engage the services of such person(s) and entity or entities as it deems reasonably necessary or appropriate in connection with the administration of the Plan.
8. Make such administrative or technical amendments to the Plan as may be reasonably necessary or appropriate to carry out the intent of the Company, including changing the funding arrangement or any other amendments as may be required or appropriate to satisfy the requirements of the Code and ERISA and the rules and regulations from time to time in effect under any such laws, or to conform the Plan with other governmental regulations or policies.
9. Pay all reasonable and appropriate expenses in connection with the management and administration of the Plan including, but not limited to, premiums or other considerations payable under the Plan and fees and expenses of any actuary, accountant, legal counsel, or other specialist engaged by the Plan Administrator.

Finality of Decisions

The Plan Administrator shall have full power, authority and discretion to enforce, construe, interpret and administer the Plan. All decisions and determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on Covered Persons and all other interested parties.

Compensation and Bonding of Plan Administrator

Unless otherwise agreed to by the Company, the Plan Administrator shall serve without compensation for services as such, but all reasonable expenses incurred in the performance of the Plan Administrator's duties shall be paid by the Employer. Unless otherwise determined by the Company or unless required by federal or state law, the Plan Administrator shall not be required to furnish bond or other security in any jurisdiction.

Liability Insurance

The Company may obtain liability coverage at the Company's expense to insure any Employee serving as Plan Administrator against legal liability that may arise from being the Plan Administrator or performing the Plan Administrator's duties.

Reserved Powers

The Company reserves the powers, among others:

1. To adopt the Plan.
2. To amend and terminate the Plan according to the Amendment, Termination, or Merger of Plan provisions contained herein.
3. To appoint and remove any claim administrator, Plan Administrator, third party administrator, or insurance company.

Power and Authority Insurance Company(ies) or Third Party Administrator(s)

Benefits under the Plan are provided through the following group policies:

Please refer to Appendix A for a list of all carriers and Component Benefit Plans.

In addition to the provisions outlined above, the insurance companies and/or Plan Administrator are responsible for determining eligibility for and the amount of any benefits payable under their respective Component Benefit Plans and prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective Component Benefit Plans.

Please contact the Plan Administrator or the appropriate claim administrator, third party administrator, or insurance company if you have any questions regarding the Plan, your eligibility, or the amount of any benefit payable under a Component Benefit Plan.

PROCEDURES

General Claims Procedures

Except as hereinafter provided, the provisions of this Section shall apply to every claim for a benefit under the Plan regardless of the basis asserted for the claim and regardless of when the act or omission upon which the claim is based occurred.

If any of the Component Benefit Plans contain claims and/or appeals procedures that comply with ERISA Section 503 and its implementing regulations, then such claims and/or appeals procedures shall be followed and shall be the appropriate procedure for making a claim and/or an appeal for a benefit covered by such Component Benefit Plan. If any Component Benefit Plan does not contain claims and/or appeals procedures that comply with ERISA Section 503 and its implementing regulations, then the applicable provisions of this Section shall override or supplement such claims and/or appeals procedures, as applicable. In addition, the provisions of this Section shall not be interpreted so as to override applicable state laws that are more protective of Covered Persons' rights with respect to claims and appeals under ERISA plans, to the extent such state laws are not preempted by ERISA.

Claims Procedure for Fully Insured and Self-Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits under the Component Benefit Plans provided under an insurance policy or through a self-insured benefit plan, the respective insurer or the designated claim administrator for the Component Benefit Plan shall have the authority to decide claims and appeals, with the full discretionary power to make factual determinations and to interpret and apply the terms of the Component Benefit Plan as they relate to the benefits provided under an insurance policy or through a self-insured benefit plan.

To obtain benefits of a Component Benefit Plan from the insurer or from the self-insured benefit plan, you must follow the claims procedures under the applicable insurance contract or self-insured benefit plan, which may require you to complete, sign and submit a written claim on a form obtained from the respective insurer or claim administrator for a self-insured benefit plan.

The insurance company or claim administrator, if a self-insured benefit plan, will decide your claim in accordance with its reasonable claims procedure, as required by ERISA. The insurance company or claim administrator, if a self-insured benefit plan, has the right to secure independent medical advice and to require such other evidence, as it deems necessary, in order to decide your claim. If the insurance company or claim administrator denies your claim, in whole or part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company or claim administrator, if a self-insured benefit plan, for a review of the denied claim. The insurance company or claim administrator, if a self-insured benefit plan, will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

You should refer to the documentation with respect to the applicable Component Benefit Plan Document(s) for more information about how to file a claim and for details regarding the insurance company's or claim administrator's, if a self-insured benefit plan, claims procedures.

Claims Deadline

Unless specifically provided otherwise in an applicable Component Benefit Plan Document or pursuant to applicable law, a claim for benefits under this Plan (including the Component Benefit Plans) must be made within one year after the date the expense was incurred that gives rise to the claim. It is the responsibility of the Covered Person or his or her designee to make sure this requirement is met.

Legal Remedy

Before pursuing a legal remedy, a Claimant shall first exhaust all claims, review, and appeals procedures required under the Plan.

Other Party Liability

Other Party Liability provisions are set forth in Component Benefit Plan Documents where applicable. The provisions of the applicable Component Benefit Plan Document shall govern with respect to benefits for injuries or illnesses of Covered Persons related to another party's actions or inactions.

Payment Procedures

Payment of Claim

Subject to the No Assignment of Benefits provision, benefits shall be payable to the Claimant upon establishment of the right thereto. Notwithstanding the foregoing, if a Claimant is adjudicated bankrupt or purports to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge any benefit payable under the Plan, voluntarily or involuntarily, the Plan Administrator, in its sole discretion, may hold or cause to be held, or apply such payment of benefit, or any part thereof, to or for the benefit of such Claimant as the Plan Administrator deems appropriate.

Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by a claim administrator, third party administrator, or insurance company for a self-insured Component Benefit Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to the applicable Component Benefit Plan and applied to the payment of current benefits and administrative fees under the Component Benefit Plan. In the event a Covered Person subsequently requests payment with respect to the voided check, the Plan Sponsor for the self-insured Component Benefit Plan shall make such payment under the terms and provisions of the Component Benefit Plan as in effect when the claim was originally processed. Unclaimed self-insured Component Benefit Plan funds may be applied only to the payment of benefits (including administrative fees) under the Component Benefit Plan pursuant to ERISA (if applicable) and any other applicable State law(s).

MISCELLANEOUS

No Employment Rights

The Plan is a voluntary undertaking of the Employer and does not constitute a contract with any person. The Plan is not an inducement or condition of an Employee's employment with any Employer. Neither the establishment of the Plan, nor any modification thereof, nor any payments hereunder, shall be construed as giving to any Employee or any other person, any legal or equitable rights against his or her Employer, the Company, or their shareholders, directors, officers, employees or agents, or as giving any person the right to be retained in the employ of the Employer.

Exclusive Rights

No individual shall have a right to benefits under the Plan except as specified herein; and in no event shall any right to benefits under the Plan be or become vested.

No Property Rights

No one has any right, title, or interest in the property of the Company or the Employer by virtue of the Plan, nor is any person entitled to interest on any benefit amounts that may be allocated or available to him or her.

No Assignment of Benefits

Except as provided in the Procedures Section, benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to effect same shall be void. Notwithstanding the foregoing, a Covered Person may direct, in writing, that benefits payable to him or her be paid instead to an institution in which he or she is or was hospitalized, to a provider of medical or dental services or supplies furnished or to be furnished to him or her, or to a person or entity that has provided or paid for, or agreed to provide or pay for, any benefits payable under the Plan. The Plan reserves the right to make payment directly to the Covered Person. No payment by the Plan pursuant to such direction and assignment shall be considered as recognition by the Plan of a duty or obligation to pay a provider of medical or dental services or supplies except to the extent the Plan actually chooses to do so.

Right to Offset Future Payments

In the event a payment or the amount of a payment is made erroneously to an individual, the Plan shall have the right to reduce future payments payable to or on behalf of such individual by the amount of the erroneous or excess payment. This right to offset shall not limit the right of the Plan to recover an erroneous or excess payment in any other manner.

Right to Recover Payments

Whenever a payment has been made by the Plan, including erroneous payments, in a total amount in excess of the amount payable under the Plan, irrespective of to whom paid, the Plan shall have the right to recover such payments, to the extent of the excess, from the person to or for whom the payment was made.

Misrepresentation or Fraud

A Covered Person who receives benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. The Plan Administrator shall decide such matters on a case by case basis.

Legal Action

Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan must first exhaust the Plan's claim, review, and appeal procedures. Unless otherwise provided by law, the Company and the Plan Administrator are the only necessary parties to any action or proceeding that involves the Plan or its administration. No Employee, Employer, or other person or entity is entitled to notice of any legal action, unless a court with appropriate jurisdiction orders otherwise.

No action at law or in equity in any court or agency shall be brought to recover benefits under the Plan prior to the exhaustion of the claims and appeals procedures set forth in the Procedures Section, nor shall an action be brought at all unless within three years after the date a claim is incurred under the Plan.

Governing Law

The provisions of the Plan shall be administered, and all questions pertaining to the validity or construction of the Plan and the acts and transactions of the parties shall be determined, construed, and enforced, in accordance with applicable federal law and, to the extent not preempted, the laws of the State of Delaware.

Governing Instrument

This document, together with the documentation incorporated by reference into it, is the legal instrument governing the Plan.

Savings Clause

If a provision of the Plan or the application of a provision of the Plan to any person, entity, or circumstance is held invalid under governing law by a court of competent jurisdiction, the remainder of the Plan and the application of the provision to any other person, entity, or circumstance shall not be affected.

Captions and Headings

The captions and headings of a Section or provision of the Plan are for convenience and reference only and are not to be considered in interpreting the terms and conditions of the Plan.

Pronouns

Unless the context otherwise demands, words importing any gender shall be interpreted to mean any or all genders.

Word Usage

Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

Notices

No notice or communication in connection with the Plan made by a Claimant, an Employee, or a Covered Person shall be effective unless duly executed on a form provided or approved by, and filed with, the appropriate Plan Administrator (or his or her representative).

Waiver

No term, condition, or provision of the Plan shall be deemed waived unless the purported waiver is in a writing signed by the party to be charged. No written waiver shall be deemed a continuing waiver unless so specifically stated in the writing, and only for the stated period, and such waiver shall operate only as to the specific term, condition, or provision waived.

Parties' Reliance

The Company, the Employer, a claim administrator, the Plan Administrator, a third party administrator(s), an insurance company(ies), and anyone to whom the Plan's operation or administration is delegated may rely conclusively on any advice, opinion, valuation, or other information furnished by any actuary, accountant, appraiser, legal counsel, or physician the Plan engages or employs. A good faith action or omission based on this reliance is binding on all parties, and no liability can be incurred for it except as the law requires. No liability shall be incurred for any other action or omission of the Company, the Employer or their employees, except for willful misconduct or willful breach of duty to the Plan.

Disclaimer

The Company makes no assertion or warranty about:

1. Health care services and supplies that Covered Persons obtain reimbursement for as Plan benefits, or
2. Whether Plan benefits will be excludable from a covered Person's gross income for federal or state income tax purposes.

Expenses

All expenses of the Plan shall be paid from Employee contributions or by the Plan, unless otherwise paid by the Employer. The Employer may advance expenses to the Plan, subject to reimbursement, without obligating itself to pay such expenses.

Indemnification

The Employer, to the extent permitted by law, shall indemnify and hold harmless any employee, officer, or shareholder of the Company or the Employer from and against all loss, damages, liability and reasonable costs and expenses incurred in carrying out his or her responsibilities under the Plan, unless due to the bad faith or willful misconduct of such person, provided that such individual's attorney's fees and any amount paid in settlement shall be approved by the Company.

AMENDMENT, TERMINATION OR MERGER OF PLAN

Right to Amend the Plan

Except as provided in this Section, the Company reserves the unlimited right to amend the Plan in any way. Any amendment to the Plan shall be in writing and shall be adopted by the Company in accordance with its normal procedures. However, the Plan Administrator shall have the authority to amend the Plan to comply with applicable law or regulation or to reflect the Company's intent.

Right to Terminate or Merge the Plan

Notwithstanding that the Plan is established with the intention that it be maintained indefinitely, the Company reserves the unlimited right to terminate or merge the Plan. Any decision to terminate or merge the Plan shall be in writing and shall be adopted by the Company in accordance with its normal procedures.

Effect of Amendment, Termination or Merger

Any amendment, termination or merger of the Plan shall be effective at such date as the Company shall determine except that no amendment, termination or merger shall reduce benefits payable for covered expenses incurred prior to the later of the date the amendment, termination or merger is effective or adopted, except as required or permitted by law.

Change in Funding Mechanism

The Company reserves the unlimited right to change, modify, cancel or otherwise terminate any of the funding arrangements available under the Contributions, Funding and Plan Assets Section, including, by way of example and not by way of limitation, the right to change insurance carriers and the right to provide previously insured benefits on a partially insured or fully uninsured basis.

HIPAA PRIVACY

The Plan provides each Covered Person with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Covered Person's personal health information. It also describes certain rights the Covered Person has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling 630-783-8900.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Covered Persons. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Covered Person's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Covered Person's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Covered Person's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.
6. Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

How Health Information May Be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.
2. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Covered Person's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information.
3. Other Covered Entities: The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Not use or disclose genetic information for underwriting purposes.
6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
7. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

Required Disclosures of PHI

1. Disclosures to Covered Persons: The Plan is required to disclose to a Covered Person most of the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Covered Person.

2. Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Covered Person's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Covered Person's Rights

The Covered Person has the following rights regarding PHI about him/her:

1. Request Restrictions: The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Covered Person has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Covered Person is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Covered Person has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Officer.
5. Access: The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Covered Person wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Covered Person and the recipient must be clearly identified. The Plan must respond to the Covered Person's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial.
6. Amendment: The Covered Person has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. Other uses and disclosures not described in this section can only be made with authorization from the Covered Person. The Covered Person may revoke this authorization at any time.

Questions or Complaints

If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Covered Person may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Covered Person with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer Contact Information:
Head of Health and Retirement
Samuel, Son & Co. (USA), Inc.
1401 Davey Road
Woodridge, IL 60517
Phone: 630-783-8900

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

- **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
        ii. Individuals described in Appendix B.
        iii. Information Technology Department.
    b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Resolution of Noncompliance

In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Covered Person's PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

STATEMENT OF ERISA RIGHTS

Covered Person's Rights

As a Covered Person in the Plan, the Covered Person is entitled to certain rights and protections under ERISA. ERISA provides that all Covered Persons are entitled to:

Receive Information About the Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

Continue health care coverage for the Employee and eligible Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. The Employee or eligible Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing the Covered Person's COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Covered Persons and beneficiaries. No one, including the Employer, the union (if any), or any other person, may fire the Employee or otherwise discriminate against the Employee in any way to prevent the Employee from obtaining a welfare benefit or exercising the Covered Person's rights under ERISA.

Enforce the Covered Person's Rights

If a Covered Person's claim for a welfare benefit is denied or ignored, in whole or in part, the Covered Person has 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 the Covered Person can take to enforce the above rights. For instance, if the Covered Person requests a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, the Covered Person may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to $110 a day until the Covered Person receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Covered Person has a claim for benefits which is denied or ignored, in whole or in part, the Covered Person may file suit in a State or Federal court. In addition, if the Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, the Covered Person may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or the Covered Person may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If the Covered Person is successful, the court may order the person the Covered Person sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees, for example, if it finds the Covered Person's claim is frivolous.

Assistance with the Covered Person's Questions

If the Covered Person has any questions about the Plan, the Covered Person should contact the Plan Administrator. If the Covered Person has any questions about this statement or about rights under ERISA, or needs assistance in obtaining documents from the Plan Administrator, the Covered Person should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the 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. The Covered Person may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX A - APPLICABLE COMPONENT BENEFIT PLANS

All of the following attachments to this Plan may be obtained from the Plan Administrator upon written request, at no charge:

Medical and Prescription Drug Benefits:
Associated Tube Union, Missouri Metals Union, Retirees and Harmony, Steel Fab and Pressure Vessel Union Plans: HDHP, HD PPO and Premium PPO
Third Party Administrator: Highmark Blue Cross Blue Shield
Group Number: 104541-30, -31, -32, -33, -34, -70, -71, -72, -80, -90
104542-10, -11, -12, -20, -21, -22, -30, -31, -32, -60, -61
104542-70, -71, -72, -80, -81, -82, -90, -91, -92
Effective January 1, 2021: 104542-33, -34, -35, -93, -94, -95
Phone: 412-544-7000

Dental Benefits:
Associated Tube Union, Missouri Metals Union, Retirees and Harmony and Pressure Vessel Union Plans: HDHP, HD PPO and Premium PPO
Third Party Administrator: United Concordia Insurance Company
Group Number: 5922653-000, -001, -002, -099, -199, -299
5922654-000, -001, -002, -099, -199, -299
Phone: 800-332-0366

Vision Benefits:
Associated Tube Union, Missouri Metals Union, Retirees and Harmony and Pressure Vessel Union Plans: HDHP, HD PPO and Premium PPO
Third Party Administrator: Highmark Blue Cross Blue Shield
Group Number: 104541-54, -55, -56, -57
Effective January 1, 2021: 104541-58, -59
Phone: 412-544-7000

Basic Life / Accidental Death and Dismemberment Benefits:
Associated Tube Union, Missouri Metals Union, Retirees and Harmony and Pressure Vessel Union Plans: HDHP, HD PPO and Premium PPO
Carrier: MetLife
Harmony,
Policy Number: 213116-2-G
251 Little Falls Drive
Wilmington, DE 19808

Short Term Disability Benefits:
Associated Tube Union, Missouri Metals Union, Retirees and Harmony and Pressure Vessel Union Plans: HDHP, HD PPO and Premium PPO (Excludes Sierra Aluminum)
Carrier: MetLife
Policy Number: 213116-1-G, 213116-2-G
251 Little Falls Drive
Wilmington, DE 19808

Long Term Disability Benefits:
Associated Tube Union, Missouri Metals Union, Retirees and Harmony and Pressure Vessel Union Plans: HDHP, HD PPO and Premium PPO
Policy Number: 213116-2-G
Carrier: MetLife
251 Little Falls Drive
Wilmington, DE 19808

Critical Illness Benefits:
Employee and Employer Paid and Voluntary
Policy Number: 213116
Group Number: 225099, 225098
Carrier: MetLife
251 Little Falls Drive
Wilmington, DE 19808

Accident Benefits:
Employee and Employer Paid and Voluntary
Policy Number: 213116
Group Number: 225101, 225100
Carrier: MetLife
251 Little Falls Drive
Wilmington, DE 19808

Hospital Indemnity Benefits:
Employee Paid and Voluntary

Policy Number: 213116
Group Number: 225102
Carrier: MetLife
251 Little Falls Drive
Wilmington, DE 19808

Health FSA Benefits:
Offered through Cafeteria Plan (Appendix C)
Administrator: Highmark Blue Cross Blue Shield
Group Number: 104542-00, -10, -11, -12, -20, -21, -22, -30, -31, -32, -33, -34, -35
104542-00, -70, -71, -72, -80, -81, -82, -90, -91, -92, -93, -94, -95
Phone: 412-544-7000

DCAP Benefits (not subject to ERISA):
Offered through Cafeteria Plan (Appendix C)
Administrator: Highmark Blue Cross Blue Shield
Group Number: 104542-00
Phone: 412-544-7000

HSA Benefits (not subject to ERISA):
Offered through Cafeteria Plan (Appendix C)
Administrator: Highmark Blue Cross Blue Shield
Group Number: 104542-00
Phone: 412-544-7000

NOTE: This Appendix A shall be subject to modification without formal amendment of the Plan.

APPENDIX B - EMPLOYEES OF THE EMPLOYER APPROVED TO HAVE ACCESS TO PROTECTED HEALTH INFORMATION

Human Resources Manager

Head of Health and Retirement
Privacy Official

Security Official

Employee Benefits Department

Legal

IT/Technology Solutions

APPENDIX C – CAFETERIA PLAN

SAMUEL, SON & CO. (USA), INC.
SECTION 125 CAFETERIA PLAN

Effective January 1, 2022

SAMUEL, SON & CO. (USA), INC.
SECTION 125 CAFETERIA PLAN

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ARTICLE 1.
INTRODUCTION

Samuel, Son & Co. (USA), Inc. (the "Company") hereby establishes the Samuel, Son & Co. (USA), Inc. Section 125 Cafeteria Plan (the "Plan"), effective as of January 1, 2022.

The purpose of this Plan is to provide eligible Employees with a choice between cash compensation and (i) coverage under applicable Benefits Options on a pre-tax basis; (ii) reimbursement for qualifying medical expenses under the Health Flexible Spending Account Plan (the "Health FSA"); (iii) reimbursement for qualifying dependent care expenses under the Dependent Care Account Plan (the "DCAP"); and/or (iv) pre-tax contributions to a Health Savings Account (the "HSA").

This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Code and any regulations promulgated from time to time thereunder, and is to be interpreted in a manner consistent therewith. That portion of the Plan providing for reimbursement of dependent care expenses is intended to qualify as a dependent care assistance program under Section 129 of the Code, and is to be interpreted in a manner consistent with the requirements of that section. That portion of the Plan providing for reimbursement of medical expenses is intended to qualify as a medical expense reimbursement plan under Section 105(b) of the Code, and is to be interpreted in a manner consistent with the requirements of Section 105 of the Code.

Notwithstanding anything in this Plan to the contrary, this Plan will be administered and interpreted to comply with the applicable requirements of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, as such amends the applicable provisions of the Code, and the applicable regulations promulgated (and other guidance issued) from time to time pursuant thereto (collectively, the "Affordable Care Act").

ARTICLE 2.
DEFINITIONS

Each following word, term, and phrase shall have the following meanings whenever such word, term, or phrase is capitalized and used in this Plan.

Section 2.01 "Affordable Care Act" means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, as such amends the applicable provisions of the Code, and the applicable regulations promulgated (and other guidance issued) from time to time pursuant thereto.

Section 2.02 "Benefit Option(s)" means the Benefit Options listed below from which an eligible Employee may select in lieu of cash compensation as described in Section 4.01 hereof:

a) Medical and prescription drug coverage
b) Dental coverage
c) Vision coverage
d) Health FSA
e) DCAP

f) HSA

Section 2.03 "Benefit Package Option" means one of the Benefit Options or, in the case of the Health Care Plans, an option for coverage under one of several options that may be available under such Health Care Plan(s).

Section 2.04 "Change in Status" means any of the events described under Section 125 of the Code that the Plan Administrator, in its sole discretion, recognizes on a uniform and consistent basis to permit an Employee to revoke an election during a Period of Coverage and make a new election, including the following:

(i) Legal Marital Status. Events that change an Employee's legal marital status, including marriage, death of Spouse, divorce, legal separation, and annulment.

(ii) Number of Dependents. Events that change an Employee's number of Dependents, including birth, death, adoption, and placement for adoption.

(iii) Employment Status. Any of the following events that change the employment status of the Employee, the Employee's Spouse, or the Employee's Dependent: (A) termination or commencement of employment; (B) a strike or lockout; (C) a commencement of or return from an unpaid leave of absence; (D) a change in worksite; or (E) any other change in employment status of the Employee or the Employee's Spouse or Dependent(s) with the consequence that such individual becomes (or ceases to be) eligible regarding Benefit Options under the Plan or similar employee benefit plan of another employer.

(iv) Dependent Satisfies or Ceases to Satisfy Eligibility Requirements. Events that cause an Employee's Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of a certain age or any similar circumstances.

(v) Residence. A change in the place of residence of the Employee, the Employee's Spouse, or the Employee's Dependent.

(vi) Adoption. A commencement or termination of adoption proceedings.

Section 2.05 "CHIPRA" means the Children's Health Insurance Program Reauthorization Act of 2009, as amended.

Section 2.06 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and the regulations issued thereunder.

Section 2.07 "Code" means the Internal Revenue Code of 1986, as amended, and its regulations.

Section 2.08 "Company" means Samuel, Son & Co. (USA), Inc., and any successor, by merger or otherwise.

Section 2.09 "Dependent" Dependent means a spouse or dependent child of an Employee who is eligible to participate in one or more Benefit Options pursuant to the terms of the applicable plan document for the Benefit Option, and who is a "dependent" within the meaning of Section 152, as modified for purposes of Code Sections 105(b) and 106. A Dependent may be eligible for coverage with respect to certain Benefit Options, but not all Benefit Options, as described in the plan documents for such Benefit Options. For purposes of reimbursing qualifying dependent care expenses under the DCAP, Dependent means the definition included in Code Sections 21 and 129, or as otherwise defined in the plan document for the DCAP.

Section 2.10 "Dependent Care Account Plan" or "DCAP" means the Samuel, Son & Co. (USA), Inc. Dependent Care Account Plan, as amended from time to time, a part of this Plan.

Section 2.11 "Effective Date" means January 1, 2022, the effective date of this Plan.

Section 2.12 "Election Period" means the periods designated by the Company and preceding (or ending on the first day of) each Period of Coverage, during which eligible Employees may enroll in one or more Benefit Options and make corresponding Salary Reduction elections under the Plan.

Section 2.13 "Employee" means an individual employed by the Employer as the common-law employee of the Employer; provided, however, that in no event shall the term "Employee" include a leased employee as defined in Section 414(n) of the Code, or any 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; nor shall any individual who is not treated as an employee of the Employer for employment tax purposes be treated as an Employee under the Plan. The term Employee does not mean any of the following persons:

1. A self-employed individual, as defined in Code Section 401(c)(1)(A),
2. A member of the board of directors of the Company who is not otherwise an Employee,
3. A person the Plan Administrator determines is an Employer's independent contractor, or
4. A person the Plan Administrator determines an Employer engages as a consultant or advisor on a retainer or fee basis.

Any person the Plan Administrator determines is not an "Employee" as defined above shall not be eligible to participate in the Plan regardless of whether such determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters. If any such person is later determined by the Plan Administrator or by a court or governmental agency to be an Employee or to have been an Employee, he or she will only be eligible for Plan participation prospectively following such determination and after the satisfaction of all other eligibility requirements.

Section 2.14 "Employer" means the Company and any subsidiary and any successor which, with the approval of the Plan Administrator, and subject to such conditions as the Plan Administrator may impose, adopts the Plan.

Section 2.15 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and its implementing regulations.

Section 2.16 "Flexible Spending Accounts" means, collectively, the Health Flexible Spending Account Plan and the Dependent Care Account Plan, each of which are a part of this Plan.

Section 2.17 "FMLA" means the Family and Medical Leave Act of 1993, as amended.

Section 2.18 "Health Care Plans" means the medical, dental, and/or vision coverages which may be designated from time to time as Benefit Options under this Plan.

Section 2.19 "Health Care Flexible Spending Account Plan" or "Health FSA" means the Samuel, Son & Co. (USA), Inc. Health FSA Plan, as amended from time to time, a part of this Plan.

Section 2.20 "Health Savings Account" or "HSA" means a Health Savings Account.

Section 2.21 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and regulations issued pursuant thereto.

Section 2.22 "Key Employee" means any individual who was, at any time during the preceding Plan Year, a "key employee" under the top-heavy provisions of Section 416(i)(1) of the Code.

Section 2.23 "Participant" means any Employee who is eligible for, and participates in, the Plan pursuant to the provisions of Article 3 hereof.

Section 2.24 "Period of Coverage" means the Plan Year, with the following exceptions: (a) the Period of Coverage for an Employee who first becomes a Participant during a Plan Year shall be the portion of that Plan Year commencing on such Employee's commencement date pursuant to Section 3.02; and (b) the Period of Coverage for an Employee who ceases to be a Participant during a Plan Year shall be the portion of the Plan Year ending on such Employee's cessation of participation date pursuant to Section 3.03. With respect to the Health FSA, the term "Period of Coverage" includes any period of continuation coverage under COBRA.

Section 2.25 "Plan" means this Samuel, Son & Co. (USA), Inc. Section 125 Cafeteria Plan, as amended from time to time.

Section 2.26 "Plan Administrator" means the person(s) authorized a responsible for managing and directing the operation and administration of the Plan in the manner described in Article 5.

Section 2.27 "Plan Year" means the 12-month period beginning on January 1 and ending on December 31. The Plan Year for each Benefit Option is set forth in the plan document of such Benefit Option.

Section 2.28 "QMCSO" means a qualified medical child support order, as that term is defined in Section 609(a) of ERISA.

Section 2.29 "Relative" means an individual who is related as described in Sections 152(d)(2)(A) through (G) of the Code, incorporating the rules of Sections 152(f)(1) and (4) of the Code.

Section 2.30 "Salary Reduction" means the amount by which a Participant's compensation may be reduced to cover the expense of the Benefit Option(s) elected by the Participant pursuant to Section 4.01. Any such Salary Reduction election must be made on a prospective basis (except as otherwise permitted by law).

Section 2.31 "Similar Coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two benefits that provide coverage for major medical are considered to be Similar Coverage. A health care flexible spending account is not Similar Coverage to an accident or health plan that is not a health care flexible spending account. Coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as Similar Coverage.

Section 2.32 "Spouse" means a person who is considered the Participant's spouse for federal income tax purposes.

ARTICLE 3.
ELIGIBILITY AND PARTICIPATION

Section 3.01 Eligibility.

(a) In General. Each Employee who as of the Effective Date participates in a Benefit Option shall be eligible to participate in this Plan as of the Effective Date. Any new Employee is eligible to participate in this Plan as of the date coinciding with his eligibility for a Benefit Option.

(b) Certain New or Divested Employees. Notwithstanding anything in the Plan to the contrary, to the extent authorized by the Company and not inconsistent with the applicable Benefit Option(s), special eligibility or other provisions or accommodations may be made under the Plan for individuals who become employees of an Employer by virtue of an acquisition by, or other transaction involving, an Employer (or a property or other business unit of an Employer); and for individuals who cease to be employees of an Employer by virtue of a divestiture by, or other transaction involving, an Employer (or a property or other business unit of an Employer).

Section 3.02 Enrollment. An 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 Benefit Options available under this Plan. If an Employee fails to make an election during his initial Election Period, the Employee shall be deemed to have elected the default Benefit Options as designated by the Company from time to time (if any).

Upon timely electing to receive a Benefit Option and agreeing to a corresponding Salary Reduction, the Employee shall become a Participant in this Plan. With respect to the Benefit Options under the Plan, any election, or deemed election, made upon such enrollment shall be irrevocable until the end of the applicable Period of Coverage unless the Participant is entitled to change his election pursuant to Section 4.06.

Section 3.03 Cessation of Participation. A Participant shall cease to be a Participant as of the earliest of the following:

(a) the date on which the Plan terminates;

(b) the date on which his benefit election for all Benefit Options is terminated; or

(c) the end of the pay period in which he ceases to be an eligible Employee (including because of his termination of employment).

Section 3.04 Reinstatement of Former Participant.

(a) A former Participant shall again become a Participant if and when he meets the requirements of Sections 3.01 and 3.02, except as otherwise provided in subsection (b) below.

(b) Except as otherwise provided under the applicable Benefit Option(s), in the event an Employee who is a Participant terminates employment and resumes employment with an Employer within a thirty (30) day period during the same Plan Year, then such Employee shall again become a Participant on the first day of active employment with the Company and the Participant's prior Benefit Option elections (or deemed elections), shall be automatically reinstated, provided he is otherwise eligible under the Plan. Notwithstanding the preceding sentence, if an event has occurred after termination and prior to rehire that would otherwise permit an election change, the rehired Employee may change his prior election accordingly.

ARTICLE 4.
BENEFITS, ELECTION PROCEDURES, AND CONTRIBUTIONS

Section 4.01 Benefit Options. An eligible Employee may choose under this Plan to receive his full compensation for any Plan Year in cash (a cash benefit) or to reduce his cash compensation and to have an amount equal to such Salary Reduction applied by his Employer toward the cost of one or more of the Benefit Options for which he is eligible.

Section 4.02 Description of Benefits Other Than Cash. While the Salary Reduction election by a Participant may be made under this Plan, the benefits or coverage under the Benefit Options he elects will be provided not by this Plan but by the particular Benefit Option(s), as applicable. The types and amounts of Benefit Options available, the requirements for participating, and the other terms and conditions of coverage and benefits are as set forth from time to time in the plan documents for the applicable Benefit Options.

Section 4.03 Election of Benefit Options in Lieu of Cash. A Participant may elect to receive one or more of the Benefit Options described in Section 4.01 in accordance with the procedure described in Section 4.04 hereof. If a Participant elects coverage under any of the Benefit Options (other than the Flexible Spending Accounts) with a premium structure otherwise requiring a contribution by the Participant towards the total cost of such coverage, the Participant's cash compensation will be reduced, and an amount equal to the Salary Reduction will be contributed by the Employer under the Benefit Option(s) in question to cover the Participant's share of the cost of such benefits as determined by the Plan Administrator. The amount of such Salary Reduction in the Participant's cash compensation shall equal the amount otherwise required as an Employee contribution by the Company as the Employee's share of the cost for the coverage under any such Benefit Options selected by the Participant, and such Salary Reduction shall be adjusted automatically in the event of a change in such required Employee contribution. The balance of the cost of such benefits shall be paid by the Employer with nonelective Employer contributions.

If a Participant elects benefits under the Health FSA, the Participant's cash compensation will be reduced and an amount equal to the Salary Reduction will be credited by the Employer to an account in accordance with the plan document (and other plan materials) for the Health FSA. The amount of such Salary Reduction and corresponding credit to the reimbursement account shall be subject to such minimum and maximum amounts per pay period as may be established from time to time by the Plan Administrator.

If a Participant elects benefits under the DCAP, the Participant's cash compensation will be reduced and an amount equal to the Salary Reduction will be credited by the Employer to an account in accordance with the plan document (and other plan materials) for the DCAP. The amount of such Salary Reduction and corresponding credit to the reimbursement account shall be subject to such minimum and maximum amounts per pay period as may be established from time to time by the Plan Administrator.

If a Participant elects to make contributions to his/her HSA through this Plan, the Participant's cash compensation will be reduced and an amount equal to the Salary Reduction will be forwarded to the HSA custodian or trustee to be deposited in the Participant's HSA. The terms of, and benefits available under, a Participant's HSA are set forth in and governed by the HSA trust or custodial agreement entered into between the Participant and the custodian or trustee of the Participant's HSA, and are not part of this plan. The HSA is not an Employer-sponsored employee benefit plan.

Section 4.04 Election Procedures. During the applicable Election Period, the Plan Administrator shall make available an election form (which may be in written, electronic, or any other form, and which shall include a Salary Reduction agreement) to each Employee who is

eligible to participate. Each Participant who desires to elect one or more of the Benefit Options described in Section 4.01 for the Plan Year shall so specify on the election form and shall agree to a corresponding Salary Reduction. Each such election form must be completed and submitted to the Plan Administrator on or before such date as the Plan Administrator shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's Salary Reduction agreement will apply. Elections made by an Employee whose employment terminates and who is rehired within 30 days shall not be treated as a newly hired eligible Employee for purposes of this Article 4 and to the extent permitted under the applicable Benefit Option.

Section 4.05 Failure to Elect. Except as provided in Sections 3.02 and 4.08, an Employee failing to return a completed election form to the Plan Administrator during the Election Period shall be deemed to have elected to receive his full compensation in cash.

Section 4.06 Irrevocability of Election by Participant During Plan Year. Elections made under the Plan (or deemed to have been made under Section 3.02 or 4.08) to receive compensation in cash or coverage under the Benefit Options, as well as an election as to the Benefit Package Option under the Health Care Plans, shall be irrevocable by the Employee during the Plan Year, subject to the following:

(a) Special Enrollment Rights. In the case of coverage under the Medical and Prescription Drug Benefit Option, a Participant may revoke an election and file a new election for the balance of the Period of Coverage that corresponds with the special enrollment rights required by HIPAA under Code Section 9801(f).

(b) Change in Status. An Employee may commence or terminate a benefit election made pursuant to Section 4.01 for the balance of a Period of Coverage if the commencement or revocation of the election is on account of, and corresponds with, a Change in Status. The consistency rules of Sections 4.06(b)(i) and (ii) must also be met. A request to terminate or commence an election under this Section 4.06(b) must be made within thirty (30) days after the Change in Status. The Plan Administrator shall have the right and authority to request and receive any documents it deems necessary to substantiate a Change in Status.

(i) Consistency Rules for Status Changes. A new election or termination of an election with respect to the Plan will satisfy the consistency rule of this Section 4.06(b) only if the new election or termination of election is on account of, and corresponds with, a Change in Status that affects eligibility for coverage under one or more of the Benefit Options, as determined by the Plan Administrator in accordance with the Code. For coverage under the Health Care Plans or the Health FSA, a Change in Status that affects eligibility includes a Change in Status that results in an increase or decrease in the number of an Employee's family members or Dependents who may benefit from coverage. An election change also satisfies the consistency rule requirements if

the change is on account of or corresponds with a Change in Status that affects expenses eligible for reimbursement under the DCAP. An election change to with respect to the Health FSA does not satisfy the consistency rule requirements (and cannot be made) if the new election would decrease the Participant's Salary Reductions for the Plan Year below the amount of reimbursements that have already been processed to that point. For example, if a Participant has elected $1,200 of annual coverage under the Health FSA ($100 Salary Reduction monthly) and has received $600 of reimbursements by the end of February (during which $200 in Salary Reductions would have been made), the Participant could not make a new election effective March 1 to decrease the Participant's Salary Reductions below $400 ($40 Salary Reduction monthly). In certain circumstances, additional requirements must be met in order to satisfy the consistency rule, as further explained below in (b)(ii) of this section.

(ii) If a Change in Status occurs as described below, then additional requirements must be met in order to satisfy the consistency rule requirements as follows:

(A) Divorce, Death, Cessation of Dependent Status. If the Change in Status is the Participant's divorce, annulment, or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the Dependent eligibility requirements, then the Participant's election to cancel any Benefit Option that is accident or health coverage for any individual other than the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or Dependent, or the Dependent that ceased to satisfy the Dependent eligibility requirements, respectively, fails to correspond with that Change in Status. As an example, if a Dependent dies or ceases to satisfy the Dependent eligibility requirements, an election to cancel any accident or health coverage for any other Dependent, for the Participant, or for the Spouse, fails to correspond with that change in Status and thus would not satisfy the consistency rule requirements.

(B) Becoming Covered Under Another Employer's Plan. If as a result of a Change in Status that involves either legal marital status or employment status, a Participant, the Participant's Spouse, or the Participant's Dependent gains eligibility for coverage under a cafeteria plan or benefit program that is sponsored by the employer of the Participant's Spouse or the Participant's Dependent, then a Participant's election under this Plan to cease or decrease coverage for that individual under this Plan corresponds with

that Change in Status only if coverage for that individual becomes applicable or is increased under the cafeteria plan or such other benefit plan sponsored by the employer of the Participant's Spouse or the Participant's Dependent.

(c) Judgment, Decree, or Order. A Participant may commence or revoke a benefit election for the balance of a Period of Coverage if the revocation or new election is on account of and corresponds with a judgment, decree, or order pursuant to a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requiring health coverage for a Participant's child or a foster child who is a Dependent of the Participant; provided, however that such health coverage must actually be provided by the individual as required by the judgment, decree, or order before the Participant can revoke an election which provides coverage to a child.

(d) Entitlement to Medicare or Medicaid. A Participant may revoke or change a benefit election with respect to the Health Care Plans or the Health FSA for the balance of a Period of Coverage if the revocation is on account of and corresponds with the Participant, Spouse, or Dependent becoming entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). In addition, if a Participant, Spouse, or Dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the Plan Administrator may allow the Participant to make a prospective election under the Plan to pay for coverage for that Participant, Spouse, or Dependent, respectively, under the Health Care Plans and/or the Health FSA.

(e) Cost Changes. THIS SECTION IS NOT APPLICABLE TO THE HEALTH FSA.

(i) Cost Changes. If the cost charged to Participants for a Benefit Option increases or decreases during a Period of Coverage and the Participants are required to make a change in their payment, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in affected Participants' Salary Reductions accordingly to reflect the new cost.

(ii) Significant Cost Changes. If the cost charged to a Participant for a Benefit Package Option significantly increases or significantly decreases during a Period of Coverage, affected Participants may make a corresponding change in election under the Plan. Changes that may be made include commencing participation in the Plan for the Benefit Package Option with a decrease in cost. In the case of an increase in cost, the Participant may revoke an election for that

coverage and, in lieu thereof, either receive on a prospective basis coverage under another Benefit Package Option providing Similar Coverage; or the Participant may drop coverage if no other Benefit Package Option providing Similar Coverage is available.

(iii) Application of Cost Changes. For purposes of this Section 4.06(e), a cost increase or decrease refers to an increase or decrease in the amount of a Participant's elective contributions (i.e., Salary Reductions) under the Plan, whether that increase or decrease results from an action taken by the Participant (such as switching between full-time and part-time status) or from an action taken by the Employer (such as reducing the amount of Employer contributions for a class of Employees).

(iv) Special Rules for Dependent Care. This Section 4.06(e) applies in the case of the DCAP only if the cost change is imposed by a dependent care provider who is not a Relative of the Participant. A cost change shall occur if the Participant increases the salary of a non-Relative household employee who provides dependent care services for the Participant.

(f) Coverage Changes. THIS SECTION IS NOT APPLICABLE TO THE HEALTH FSA.

(i) Significant Curtailment Without Loss of Coverage. If a Participant (or his Spouse or Dependent) has a significant curtailment of coverage under the Health Care Plans or the DCAP during a Period of Coverage that is not a loss of coverage as described below in paragraph (f)(iii) (for example, there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost sharing limit under the Health Care Plans or as a result of a Dependent starting school, there is a decrease in the amount of child care expenses to be reimbursed under the DCAP), then any Participant who has been participating in the Plan and receiving that coverage may revoke his election for that coverage and, in lieu thereof, elect to receive on a prospective basis coverage under another Benefit Package Option providing Similar Coverage. Coverage is significantly curtailed only if there is an overall reduction in coverage provided under the Plan so as to constitute reduced coverage generally. Thus, in most cases, the loss of one particular physician in a network does not constitute a significant curtailment.

(ii) Significant Curtailment With Loss of Coverage. If a Participant (or his Spouse or Dependent) has a significant curtailment that is a loss of coverage as described below in paragraph (f)(iii), then the Participant may revoke his election under the Plan and, in lieu thereof, may elect either to receive on a prospective basis coverage

under another Benefit Option providing Similar Coverage or to drop coverage if no Similar Coverage is available.

(iii) Loss of Coverage. A loss of coverage means a complete loss of coverage under the Benefit Package Option or other coverage option under any of the Health Care Plans or the DCAP (including the elimination of a Benefit Package Option in a Health Care Plan, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the Health Care Plan by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its discretion, may treat the following as a loss of coverage: (A) a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or in an HMO); (B) a reduction in the benefits for a specific type of medical condition or treatment with respect to which a Participant (or his Spouse or Dependent) is currently in the course of treatment; or (C) any other similar fundamental loss of coverage.

(iv) Addition or Improvement of a Benefit Option. If any of the Benefit Options add a new Benefit Package Option or other coverage option, or if coverage under an existing Benefit Package Option or other coverage option is significantly improved during a Period of Coverage, then a Participant (whether or not the Participant has previously made an election under the Plan or has previously elected that Benefit Package Option) may revoke his election under the Plan and, in lieu thereof, make an election on a prospective basis for the duration of the Period of Coverage to pay for coverage under the new or improved Benefit Package Option or other coverage option.

(v) Change in Coverage Under Another Employer Plan. A Participant may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the same Employer or of another employer) if (A) the other cafeteria plan or qualified benefits plan permits participants to make an election change that would be permitted by IRS regulations under Section 125 of the Code, as generally described in this Section 4.06; or (B) this Plan permits Participants to make an election for a period of coverage that is different from the Period of Coverage under the other cafeteria plan or qualified benefits plan.

(vi) Loss of Coverage Under Other Group Health Coverage. A Participant may make an election on a prospective basis to add coverage for a Benefit Option for the Participant, Spouse, or the

Participant's Dependent if such Participant, Spouse, or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including any one of the following: (A) a State's Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act; (B) a medical care program of an Indian tribal government as defined in Section 7701(a)(40) of the Code, the Indian Health Service, or a tribal organization; (C) a State health benefits risk pool; or (D) a Foreign government group health plan.

(g) Temporary Election Changes Allowed for 2022 Plan Year. Pursuant to IRS Notice 2020-29, this Plan permits a Participant to make a change to the Participant's Health FSA election for the 2022 Plan Year, regardless of whether or not an event described in (a) through (i) above applies, including:

(i) Increasing or decreasing a current election; or

(ii) Revoking an election.

A Participant may only make these changes prospectively and only during the 2022 Plan Year. Elections to decrease the Health FSA coverage amount are limited to no less than amounts already reimbursed to the Participant for the 2022 Plan Year.

Any new election under this Section 4.06 shall be effective at such time as the Plan Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Plan Administrator (except as otherwise permitted by law).

Section 4.07 Participation During FMLA Leave of Absence. SUBSECTIONS (a), (b) AND (c) ARE NOT APPLICABLE TO THE DCAP.

(a) FMLA Requirements in General. The FMLA generally requires an Employer to offer coverage under any group health plan for the duration of a leave that is required to be extended by the FMLA, whether the leave is paid or unpaid. The group health plan coverage is to be offered under the same conditions as coverage would have been provided if the Participant had been continuously working during the entire leave period. The Participant has the right to keep this coverage by continuing to pay his cost of the premium. In addition, a Participant on FMLA leave has the right to revoke or change elections under the same terms and conditions as are available to active Employees. The provisions of this Section 4.07 address election choices under this Plan when the Employee is on FMLA leave. However, nothing herein shall be construed to alter the terms of any underlying benefit plan documentation and should not be construed to grant coverage under a Benefit Option when the documentation for that Benefit

Option would not allow coverage to continue during a leave of absence, except as may be required by FMLA.

(b) Health Benefits. To the extent required by FMLA, with regard to a Participant who takes an unpaid FMLA leave of absence, the Employer must either:

(i) permit the Participant to revoke coverage under any of the Health Care Plans and/or the Health FSA while on FMLA leave; or

(ii) continue coverage under the Health Care Plans and/or the Health FSA for the Participant (i.e., without allowing any option by Participant to revoke coverage), in which case the Participant shall be allowed to discontinue payment of the required premiums during the period of unpaid FMLA leave and the Employer may recover the Participant's share of the unpaid premiums when the Participant returns to work as provided in Section 4.07(c)(3).

If a Participant is permitted to elect to terminate coverage as described above for the Health Care Plans and does terminate coverage, or if the Participant continues coverage yet coverage terminates because the Participant fails to pay the required premium, then there will be no coverage under the Health Care Plans following such termination and expenses incurred after termination are not eligible for payment. If the Participant is permitted to elect to terminate coverage as described above for the Health FSA, or if the Participant continues coverage yet coverage terminates because the Participant fails to pay the required premium, then the Participant is not entitled to receive reimbursements for claims incurred during the period while the coverage is terminated, and if the Employer requires the Participant to be reinstated in the Health FSA (or the Participant elects to be reinstated) for the remainder of the Plan Year upon return from FMLA leave, the Participant may not retroactively elect coverage for claims incurred during the period when the coverage was terminated.

(c) Payment of Premium While on Unpaid FMLA Leave. If a Participant takes an unpaid FMLA leave, is offered an election to terminate coverage under the Health Care Plans and/or the Health FSA, but elects to continue coverage, the Employer shall permit the Participant to pay his share of the premium by one of more of the following methods, selected by the Employer, which option or options must be offered in accordance with regulations under Section 125 of the Code relating to cafeteria plans and FMLA leaves, and in accordance with the Employer's practices and procedures:

(1) Pre-Pay. A Participant may pre-pay the premium for the expected duration of the leave either with after-tax dollars or with pre-tax dollars from any taxable compensation of the Participant. Pre-tax dollars may not be used to pre-pay coverage during the subsequent Plan Year, and pre-payment may not be the sole method made available.

(2) Pay-As-You-Go. A Participant may make premium payments during the course of the FMLA leave by sending such payments on the same schedule as payments would have been made if the Participant were not on leave, or on a similar schedule to premium payments for COBRA coverage, or on any other basis as authorized by the Employer. Contributions under this option are generally made on an after-tax basis. Coverage may cease if payments are not timely made, in accordance with the FMLA and its requirements. Alternatively, the Employer may choose to continue the health coverage of the Participant who fails to pay premiums, in which case the Employer may recoup the premiums paid on the Participant's behalf, to the extent authorized by regulations.

(3) Catch-Up. At the Employer's discretion, a Participant may make an advance agreement with the Employer that coverage will continue during the leave and that the Participant will not pay premiums until returning from the leave, after which time the Participant will catch-up those premium payments. When a Participant fails to make required premium payments while on unpaid FMLA leave, the Employer may recoup the Participant's share of premium payments after the Participant's return, no agreement with the participant being required in this situation. Catch-up contributions may be made on a pre-tax salary reduction basis from any taxable compensation of the Participant or from after-tax compensation.

(4) Other. If any other option is made available to Employees on non-FMLA leave, then such option is also available to Employees on FMLA leave.

The Employer is not required to continue coverage under the Health Care Plans and/or the Health FSA for Participants who fail to make required premium payments while on FMLA leave, provided that the Employer follows the notice procedures required under FMLA.

(d) Payment of Premium While on Paid FMLA Leave. To the extent that a Participant continues Benefit Options during paid FMLA leave, premium payments shall be continued on the same basis as existed prior to the leave; that is, pursuant to Section 4.01 hereof through reduction of the Participant's cash compensation. If the premium payments exceed or are expected to exceed a Participant's cash compensation during paid FMLA leave, then the Employer shall permit the Participant to pay such excess amount by one or more of the methods listed under Section 4.07(c).,

(e) DCAP Benefits. A Participant who takes FMLA leave shall be permitted to revoke his election for benefits under the DCAP in accordance with the provisions of this Plan other than this Section 4.07 (e.g., a Change in Status described in Section 2.04(iii)). If the Participant elects to continue coverage for benefits under the DCAP during the period of FMLA leave, the Employer may require payment of Participant's share of the premium under any of the methods selected by the Employer, specified in Section 4.07(c). If the Participant's coverage under the DCAP terminates while on FMLA leave, the Participant is not entitled to receive reimbursements for expenses incurred during the period while the coverage is terminated.

(f) Coverage Upon Return from FMLA Leave. A Participant whose coverage under this Plan, the Health Care Plans, or the Flexible Spending Accounts terminates while the Participant is on FMLA leave (either by revocation by the Participant or nonpayment of premiums) shall be permitted to resume participation in any of the foregoing plans under the same terms and conditions that existed prior to the FMLA leave (including family or dependent coverage under the Health Care Plans). However, any terms and conditions that may have changed for active Employees also apply to the Participant returning from FMLA leave. Upon return from FMLA leave during which coverage terminated, the Employer may require reinstatement into the Health FSA, provided that Participants on a non-FMLA leave are also required to be reinstated into the Health FSA. Upon reinstatement, whether or not required, the Participant may not retroactively elect coverage for claims incurred during the period when the coverage was terminated. The Participant has the right (i) to resume coverage at the level in effect prior to the beginning of the leave, thus increasing premium payments upon return from the leave or, alternatively, (ii) to resume coverage at a reduced level, continuing premium payments in the same amount as in effect before the leave, in which case the reduction in coverage is prorated for the period of FMLA leave during which no premiums were paid. For example, if a Participant has elected $1,200 of annual coverage under the Health FSA ($100 Salary Reduction monthly) and is on FMLA

leave during April, May, and June, during which time coverage ceases, the Participant on return from the leave in July may resume coverage at $1,200 by paying $150 per month from July through December. Alternatively, the Participant may resume coverage at the reduced level of $900 annually by paying $100 per month from July through December.

Section 4.08 Health Benefits - Participation During Short Term Disability - Paid Leave of Absence.

(a) Benefit Coverage while on Short Term Disability - Paid Leave of Absence. The employer will continue to offer coverage under any group health plan for the duration of leave (26 weeks). The group health plan coverage is to be offered under the same conditions as coverage would have been provided if the Participant had been continuously working during the entire leave period. The Participant has the right to keep this coverage by continuing to pay his cost of the premium. In addition, a Participant on Short Term Disability leave has the right to revoke or change elections under the same terms and conditions as are available to active Employees. The provisions of Section 4.08 address election choices under this Plan when the Employee is on STD leave. However, nothing herein shall be construed to alter the terms of any underlying benefit plan documentation and should not be construed to grant coverage under a Benefit Option when the documentation for that Benefit Option would not allow coverage to continue during a STD, paid leave of absence.

(b) Health Benefits – Participant Contributions. Regarding a Participant who takes a Short Term Disability - Paid Leave of Absence, the Employer will either:

(i) permit the Participant to revoke coverage under any of the Health Care Plans and/or the Health FSA while on STD leave; or

(ii) continue coverage under the Health Care Plans and/or the Health FSA for the Participant (i.e., without allowing any option by Participant to revoke coverage), in which case the Participant shall be allowed to discontinue payment of the required premiums during the period of paid STD leave and the Employer may recover the Participant's share of the unpaid premiums when the Participant returns to work.

If a Participant is permitted to elect to terminate coverage as described above for the Health Care Plans and does terminate coverage, or if the Participant continues coverage yet coverage terminates because the Participant fails to pay the required premium, then there will be no coverage under the Health Care Plans following such termination and expenses incurred after termination are not eligible for payment. If the Participant is permitted to elect to terminate coverage as described above for the Health FSA, or if the Participant continues coverage yet coverage terminates because the Participant fails to pay the required premium, then the Participant is not entitled to receive reimbursements for claims incurred during the period while the coverage is terminated, and if the Employer requires the Participant to be reinstated in the Health FSA (or the Participant elects to be reinstated) for the remainder of the Plan Year upon return from Short Term Disability - Paid Leave of Absence, the Participant may not retroactively elect coverage for claims incurred during the period when the coverage was terminated.

(c) Payment of Premium While on paid Short Term Disability Leave. If a Participant takes STD leave, is offered an election to terminate coverage under the Health Care Plans and/or the Health FSA, but elects to continue coverage, the Employer shall permit the Participant to pay his share of the premium by one of more of the following methods, selected by the Employer, which option or options must be offered in accordance with regulations under Section 125 of the Code relating to cafeteria plans and STD leaves, and in accordance with the Employer's practices and procedures:

(1) Pre-Pay. A Participant may pre-pay the premium for the expected duration of the leave either with after-tax dollars or with pre-tax dollars from any taxable compensation of the Participant. Pre-tax dollars may not be used to pre-pay coverage during the subsequent Plan Year, and pre-payment may not be the sole method made available.

(2) Pay-As-You-Go. A Participant may make premium payments during the course of the STD leave by sending such payments on the same schedule as payments would have been made if the Participant were not on leave, or on a similar schedule to premium payments for COBRA coverage, or on any other basis as authorized by the Employer. Contributions under this option are generally made on an after-tax basis. Coverage may cease if

payments are not timely made, in accordance with the STD and its requirements. Alternatively, the Employer may choose to continue the health coverage of the Participant who fails to pay premiums, in which case the Employer may recoup the premiums paid on the Participant's behalf, to the extent authorized by regulations.

(3) Catch-Up. At the Employer's discretion, a Participant may make an advance agreement with the Employer that coverage will continue during the leave and that the Participant will not pay premiums until returning from the leave, after which time the Participant will catch-up those premium payments. When a Participant fails to make required premium payments while on STD paid leave, the Employer may recoup the Participant's share of premium payments after the Participant's return, no agreement with the participant being required in this situation. Catch-up contributions may be made on a pre-tax salary reduction basis from any taxable compensation of the Participant or from after-tax compensation.

The Employer is not required to continue coverage under the Health Care Plans and/or the Health FSA for Participants who fail to make required premium payments while on STD paid leave, provided that the Employer follows the notice procedures under STD.

(d) Payment of Premium While on Paid Short Term Disability - Leave of Absence. To the extent that a Participant continues Benefit Options during paid Short Term Disability - Leave of Absence, premium payments shall be continued on the same basis as existed prior to the leave; that is, pursuant to Section 4.01 hereof through reduction of the Participant's cash compensation. If the premium payments exceed or are expected to exceed a Participant's cash compensation during Short Term Disability - Paid Leave of Absence, then the Employer shall permit the Participant to pay such excess amount by one or more of the methods listed under Section 4.07(c).,

(e) DCAP Benefits. A Participant who takes Short Term Disability - Paid Leave of Absence shall be permitted to revoke his election for benefits under the DCAP in accordance with the provisions of this Plan other than this Section 4.07 (e.g., a Change in Status described in Section 2.04(iii)). If the Participant elects to continue coverage for benefits under the DCAP during the period of Short Term Disability - Paid Leave of Absence, the Employer may require payment of Participant's share of the premium under

any of the methods selected by the Employer, specified in Section 4.07(c). If the Participant's coverage under the DCAP terminates while on Short Term Disability - Paid Leave of Absence, the Participant is not entitled to receive reimbursements for expenses incurred during the period while the coverage is terminated.

(f) Coverage Upon Return from Short Term Disability - Paid Leave of Absence. A Participant whose coverage under this Plan, the Health Care Plans, or the Flexible Spending Accounts terminates while the Participant is on Short Term Disability - Paid Leave of Absence (either by revocation by the Participant or nonpayment of premiums) shall be permitted to resume participation in any of the foregoing plans under the same terms and conditions that existed prior to the Short Term Disability - Paid Leave of Absence (including family or dependent coverage under the Health Care Plans). However, any terms and conditions that may have changed for active Employees also apply to the Participant returning from Short Term Disability - Paid Leave of Absence. Upon return from Short Term Disability - Paid Leave of Absence during which coverage terminated, the Employer may require reinstatement into the Health FSA, provided that Participants on a non-Short Term Disability - Paid Leave of Absence are also required to be reinstated into the Health FSA. Upon reinstatement, whether required, the Participant may not retroactively elect coverage for claims incurred during the period when the coverage was terminated. The Participant has the right (i) to resume coverage at the level in effect prior to the beginning of the leave, thus increasing premium payments upon return from the leave or, alternatively, (ii) to resume coverage at a reduced level, continuing premium payments in the same amount as in effect before the leave, in which case the reduction in coverage is prorated for the period of Short Term Disability - Paid Leave of Absence during which no premiums were paid. For example, if a Participant has elected $1,200 of annual coverage under the Health FSA ($100 Salary Reduction monthly) and is on Short Term Disability - Paid Leave of Absence during April, May, and June, during which time coverage ceases, the Participant on return from the leave in July may resume coverage at $1,200 by paying $150 per month from July through December. Alternatively, the Participant may resume coverage at the reduced level of $900 annually by paying $100 per month from July through December.

Section 4.09 Continuation of Previous Election. With respect to any Plan Year for which the Plan Administrator does not require active enrollment, a Participant who fails to return a completed election form to the Plan Administrator on or before the specified due date shall be deemed to have made the same election as was in effect as to such benefits and coverage under the Benefit Options, other than the Flexible Spending Accounts, for the preceding Plan Year. This deemed election shall include an election and corresponding Salary Reduction agreement for the subsequent Plan Year equal to the amount otherwise required as an Employee contribution by the

Company as the Participant's share of the cost for the same coverage under the Benefit Options as the Participant is deemed to have elected. However, such a Participant failing to return a completed election form on or before the specified due date for any Plan Year shall be deemed not to have elected benefits under the Flexible Spending Accounts. Notwithstanding the foregoing, a Participant may terminate his participation at the end of any Plan Year by written or electronic notice to the Plan Administrator delivered before the first day of the succeeding Plan Year. With respect to any Plan Year for which the Plan Administrator does require active enrollment, a Participant who fails to return a completed election form to the Plan Administrator on or before the specified due date shall be deemed not to have elected any benefits or coverage under the Benefit Options.

Section 4.10 Automatic Termination of Election. Elections made under this Plan (or deemed to be made under Section 3.02 (if any) or 4.08) 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 Employer, or (b) the date of termination of the Participant's status as an Employee. Notwithstanding the termination of the election, coverage or benefits under the Benefit Options may continue if and to the extent provided thereby.

Section 4.11 Maximum Employer Contributions. The maximum amount of Employer contributions under the Plan for any Participant shall be the sum of (a) the maximum amount which the Participant may receive in the form of medical reimbursements under the Health FSA, (b) the maximum amount which the Participant may receive in the form of child or other dependent care reimbursements under the DCAP, (c) the maximum amount which the Participant may contribute to his or her HSA and (d) the costs of the most expensive benefits available to the Participant under the other Benefit Options including the portion of such costs payable with nonelective Employee contributions.

Section 4.12 Nondiscriminatory Benefits. The Plan is intended not to discriminate in favor of highly compensated individuals as to eligibility to participate, or with respect to contributions or benefits, and to comply in this respect with the requirements of the Code. If, in the judgment of the Plan Administrator, the operation of the Plan in any Plan Year would result in such discrimination, the Plan Administrator shall select and exclude from coverage under the Plan such Participants, or reduce Plan contributions or Benefit Options under the Plan for highly compensated Participants, all as shall be necessary to assure that the Plan does not discriminate. In no event shall the total contributions for any Plan Year to the Benefit Options on behalf of Participants who are Key Employees exceed twenty-five percent (25%) of the aggregate contributions on behalf of all Participants. If the Plan Administrator determines during any Plan Year that this requirement may not be satisfied, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants who are Key Employees, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections and agreements to reduce cash compensation by Participants who are Key Employees for the remainder of the Plan Year, with or without the consent of such Key Employees.

Section 4.13 Health FSA Carryover. The terms and conditions of the Health FSA are described in the plan document and other plan materials for the Health FSA. Unless such plan documents or materials state otherwise, the Health FSA contains a "carryover" feature, which

permits unused amounts (up to a specified maximum) in a Participant's Health FSA account at the end of a Plan Year to be carried over and used to reimburse the Participant for qualifying medical expenses incurred during the subsequent Plan Year. The maximum carryover amount permitted by this Plan is the maximum amount permitted by the IRS for the applicable Plan Year. Specifically, this Plan adopts the maximum carryover amount as allowed in IRS Notice 2020-33, making the maximum carryover amount an amount equal to 20 percent of the maximum Health FSA Salary Reduction for that Plan Year. For example, the maximum unused amount from the 2022 Plan Year allowed to be carried over to the 2021 Plan Year is $550 (20 percent of $2,750, the indexed 2022 limit for a Health FSA Salary Reduction).

Section 4.14 DCAP Grace Period. The terms and conditions of the DCAP are described in the plan document and other plan materials for the DCAP. Unless such plan documents or materials state otherwise, the DCAP contains a "grace period" feature, which generally permits unused amounts remaining in a Participant's DCAP account at the end of the Plan Year to be used to reimburse the Participant for qualifying dependent care expenses that are incurred during the grace period immediately following the close of that Plan Year (subject to conditions and limitations set forth in the applicable plan document and plan materials). Such grace period begins immediately following the close of a Plan Year and ends on the day that is 2 months plus 15 days following the close of that Plan Year.

ARTICLE 5.
ADMINISTRATION OF PLAN

Section 5.01 Plan Administrator. The administration of the Plan shall be by the Plan Administrator.

Section 5.02 Power, Duties, and Responsibilities of the Plan Administrator. The Plan Administrator shall administer and supervise the day-to-day operation of the Plan in accordance with its terms and provisions. The primary responsibility of the Plan Administrator is to administer the Plan for the exclusive benefit of persons entitled to participate in the Plan and their beneficiaries (without discrimination among them), subject to the specific terms of the Plan. The Plan Administrator will have full power and authority to administer the Plan in all of its details (including absolute discretion with respect to the exercise of such power and authority), subject to applicable legal requirements. In performing its duties, the Plan Administrator shall have discretionary authority to grant or deny benefits under this Plan. Notwithstanding the foregoing sentence, the Plan Administrator shall have no power to add to, subtract from or modify any of the terms of the Plan, or to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under 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, 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 construe and interpret the Plan;

(c) to decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(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 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; and

(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.

Notwithstanding the foregoing, any claim which arises under Benefit Options shall not be subject to review under this Plan, and the Plan Administrator's authority under this Section 5.02 shall not extend to any matter as to which an administrator under any such other plan is empowered to make determinations under such plan.

Section 5.03 Claims and Review Procedures. Any claim for benefits under a Benefit Option shall be determined in accordance with the claims and review procedures thereunder.

Section 5.04 Records and Reports. The Plan Administrator shall keep a record of all actions taken and shall keep all other books of account, records, and other data that may be necessary for proper administration of the Plan and shall be responsible for supplying all information and reports to governmental agencies or departments, Participants, beneficiaries, and others as required by law. The Plan Administrator shall make available to each Participant such of his records under the Plan as pertain to him, for examination at reasonable times during normal business hours.

Section 5.05 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 which are furnished by, or in accordance with the instructions of, the administrators of the Benefit Options, or by legal counsel, accountants, actuaries, consultants, experts, specialists, advisers, or other persons employed or engaged by the Plan Administrator.

Section 5.06 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 all persons similarly situated will receive substantially the same treatment.

Section 5.07 Indemnification. The Employer shall indemnify an employee acting as the Plan Administrator, and each member thereof if a committee is Plan Administrator, and any other employees and directors involved in the administration of the Plan, against all liability, claims, damages and expense, including fees of individuals appointed pursuant to Section 5.02(e), for any act of omission or commission performed by such persons while acting in good faith in discharging

their duties with respect to the Plan, unless arising from the gross negligence or willful misconduct of such persons. This indemnification shall be limited to the costs and expenses which are not covered under insurance as may be provided by the Employer.

Section 5.08 Expenses of Administration. All expenses incurred prior to the termination of the Plan that shall arise in connection with the administration of the Plan, including but not limited to administrative expenses and 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.

ARTICLE 6.
AMENDMENT AND TERMINATION OF PLAN

Section 6.01 Amendment of Plan. The Company shall have the right at any time, and from time to time, to modify, alter or amend the Plan in whole or in part effective as of a specified date or dates and may make any amendment retroactive if deemed necessary or appropriate.

Section 6.02 Termination of Plan. The Company shall have the right to terminate the Plan at any time, effective as of such date as it may determine. All Salary Reduction agreements shall terminate as of the effective date of the Plan's termination.

ARTICLE 7.
MISCELLANEOUS PROVISIONS

Section 7.01 Information to be Furnished. Each Participant shall provide the Employer and the Plan Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

Section 7.02 Limitation of Rights. Neither the establishment of this Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against an Employer or the Plan Administrator, except as provided herein. Neither the establishment of this Plan nor any amendment thereof, 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. Nothing contained in this Plan shall give a Participant or any other person any right, title or interest in any property of any Employer.

Section 7.03 Applicable Law. Except to the extent federal law is controlling, the provisions of this Plan shall be interpreted, construed, administered, and enforced according to the laws of the State of Tennessee, except for those matters specifically governed by the corporation laws of the State of Delaware. The Plan is intended to be a cafeteria plan under Section 125 of the Code and shall be construed accordingly.

Section 7.04 Headings. The headings and subheadings of articles and sections are included 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.

Section 7.05 Gender and Number. Whenever any words are used herein in the masculine, feminine, or neutral gender, they shall be construed as though they were also used in another gender 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.

Section 7.06 Severability of Provisions. The provisions of this Plan are severable, and should any provision be ruled illegal, unenforceable, or void, all other provisions not so ruled shall remain in full force and effect.

IN WITNESS WHEREOF, the Company has caused this Plan to be duly executed for and on its behalf by its duly authorized representative, effective as of January 1, 2022.

SAMUEL, SON & CO. (USA), INC.

By: _____

Title: Head of Health & Retirement Plans - US