WHOA & CO, INC. HEALTH & WELFARE BENEFITS PLAN

d/b/a Eldridge Electric Company and Triple R Electric, Inc.

Wrap Plan Document & Summary Plan Description

Effective Date July 1, 2026

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I. INTRODUCTION

This document, together with the applicable insurance contracts, benefit booklets, certificates of coverage, subscriber agreements, administrative service agreements, and any related policies or provider descriptions (collectively, the "Component Benefit Plan Documents"), constitutes the Wrap Summary Plan Description ("Wrap SPD") for the Whoa & Co, Inc. Health and Welfare Benefits Plan (the "Plan"). This Wrap SPD also serves as the written plan document required under the Employee Retirement Income Security Act of 1974 ("ERISA") for all component welfare benefit programs covered by the Plan.

This Wrap SPD combines, amends, and restates in its entirety any prior health and welfare plan wrap document or SPD maintained by the Company, effective as of July 1, 2026**,** and supersedes all prior plan documents. The purpose of the Plan is to provide welfare benefits to certain employees of the Company and, in accordance with the dependent coverage provisions of the Plan, to their eligible spouses and dependents.

This Wrap SPD constitutes the governing plan document and SPD for the Company's Plan and presents information about all the health and welfare benefit plans maintained by Company. It describes the structure of the Plan, identifies its component benefit programs, and summarizes your rights and obligations as a participant. Please read this Wrap SPD carefully and keep it, together with your other plan materials, for future reference. The complete Plan and all related documents are available from the Plan Administrator upon request.

The Plan consists of various Component Benefit Plans, some of which are self-funded, and others which are insured. The specific terms, conditions, and limits of each benefit are set forth in the governing documents for those Component Benefit Plans—such as insurance policies, certificates of coverage, administrative service agreements, and benefit booklets (collectively, the "Component Benefit Plan Documents"). These documents are incorporated into this Wrap SPD by reference. If there is any conflict between this Wrap SPD and a Component Benefit Plan Document, the terms of the Component Benefit Plan Document will control. A summary of each Component Benefit Plan is provided in Appendix B. For additional information, contact Leti Aguilar, Employee Benefits Contact, at (210) 695-9113 or accounting@eldridge-electric.com.

This Wrap SPD, including its appendices and all Component Benefit Plan Documents, constitutes the written plan document for purposes of compliance with ERISA § 402(a). The Plan is an employee welfare benefit plan within the meaning of ERISA § 3(1) and complies with all applicable federal requirements, including the Consolidated Appropriations Act of 2021, COBRA, HIPAA, the Newborns' and Mothers' Health Protection Act, the Mental Health Parity and Addiction Equity Act, the Women's Health and Cancer Rights Act, and the Genetic Information Nondiscrimination Act, as applicable.

This Wrap SPD contains a summary in English of your rights and benefits under the Whoa & Co, Inc. Plan. If you have difficulty understanding any part of this Wrap SPD, contact your Plan Administrator for assistance.

II. PLAN INFORMATION

Type of Plan: Employee Welfare Benefit Plan, including the following Component

Benefit Plans and Programs:

- Medical (Self-Funded)
- Prescription Drug (Self-Funded, provided as part of the Medical Plan)
- Dental
- Vision
- Basic Group Term Life Insurance
- Basic Accidental Death & Dismemberment ("AD&D")
- Voluntary Term Life and AD&D
- Short-Term Disability ("STD") (Voluntary)
- Long-Term Disability ("LTD")
- Hospital Indemnity
- Critical Illness
- Accident

See Appendix B, the Welfare Benefits Chart, for a list of all of the above Component Benefit Plans, with relevant contact information. You will receive plan documents for each Component Benefit Plan described above; each Component Benefit Plan Document will contain information about eligibility, benefits, claims procedure and funding under the specific Component Benefit Plan. If you are eligible to participate in any one of the Component Benefit Plans, then you are eligible to participate in this Plan.

The Company maintains Medical, Prescription Drug, Dental and Vision coverage through a Section 125 Cafeteria Plan for the exclusive benefit of its employees and certain individuals related to its employees, such as employees' spouses and dependents.

Plan Year: July 1 through June 30 of each year

Plan Sponsor: Whoa & Co, Inc.
d/b/a Eldridge Electric Company and Triple R Electric, Inc.
1359 Rodalyn Drive, Boerne, TX 78006
Mailing: PO Box 1289, Helotes, TX 78023
(210) 695-9113

Plan number: 501

Plan Sponsor's Employer Identification Number ("EIN"): 85-3285923

Plan Administrator/ Plan Fiduciary:
Whoa & Co, Inc.
1359 Rodalyn Drive, Boerne, TX 78006
Attn: Leti Aguilar, Employee Benefits Contact
(210) 695-9113 | accounting@eldridge-electric.com

Agent for service of Legal Process:
Whoa & Co, Inc. (Plan Administrator)
1359 Rodalyn Drive
Boerne, TX 78006
(210) 695-9113

Plan Administration: Plan benefits are provided under contracts between the Plan or Plan Sponsor and insurance carriers and third-party administrators ("TPAs"). Plan benefits are funded via insured policies and from Whoa & Co, Inc. general assets, which may include contributions from Employees for participation in one or more of the Component Benefit Plans. The Medical and Prescription Drug benefits are self-funded and are supported by a medical stop-loss insurance policy issued to the Plan Sponsor by Complete Captive Management Services, LLC (Policy No. W&C 111 26099 MSL). The stop-loss policy reimburses the Plan Sponsor for certain claims; it does not provide benefits directly to, or create any rights for, Participants. All other Component Benefit Plans are fully insured by Mutual of Omaha.

Third Party Administrators:

<u>For the Self-Funded Medical Plan (Claims Administrator):</u>
Coastal Administrative Services, Inc.
Group No. 22501350
P.O. Box 3070
Bellingham, WA 98227
855-373-8232

<u>For the Prescription Drug Benefit (PBM)</u>:
US-Rx Care
Group No. 22501350P2
4600 Sheridan Street, Suite 200
Hollywood, FL 33021
877-200-5533

<u>For Utilization Review / Pre-Authorization</u>:

Innovative Care Management, Inc.
PO Box 22386
Portland, OR 97269
800-862-3338

For COBRA Administration:
Diversified Administration, Inc.
6600 Taft St #304
Hollywood, FL 33024
954-983-9970
cobra@div125.com

III. PLAN ADMINISTRATION

The Plan Administrator is responsible for the general administration of the Plan, including the Component Benefit Plans, and is the "Plan Administrator," and "Named Fiduciary" within the meaning of ERISA except to the extent another person or entity is specifically designated in any of the Component Benefit Plans in connection with the performance of specific functions. For the Component Benefit Plans that are fully insured, unless specifically provided otherwise in the Component Benefit Plan Documents, the Insurer is the "Named Fiduciary," and Claims Fiduciary responsible for administering the Component Benefit Plan, as well as the Claims Administrator for determining benefits under the Component Benefit Plan. When the Insurer is the Claims Fiduciary and Claims Administrator, it shall have full authority and discretion to interpret the terms of the Component Benefit Plan for those purposes. At all times, Whoa & Co, Inc., as the Plan Sponsor, retains ultimate authority to make final determinations regarding the administration of the Plan and the determination of benefits and interpretation of terms under the Component Benefit Plans.

With respect to the Plan, including the Component Benefit Plans, the Plan Administrator has the following discretionary authority, duties and powers:

1) The authority to make and enforce such rules and regulations as it deems necessary 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. Any provisions in the Plan or in the Component Benefit Plan Documents that are not in accordance with, or are in conflict with, applicable law are void and unenforceable. This includes any and all gag clauses that may still exist in one or more service(s) agreements with TPAs and/or insurers of the Component Benefit Plans that provide access to a network of providers or pharmacies.
2) The authority to interpret the provisions of the Plan, make findings of fact, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

3) The authority to decide all questions concerning the Plan and the eligibility of any person to participate in the Plan.

4) The authority to appoint such agents, counsel, accountants, consultants and other service providers or Business Employees as may be required to assist Plan Administrator in administering the Plan and monitoring other Plan service providers.

5) The authority to allocate and delegate fiduciary and administrative responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, as long as any such allocation, delegation, or designation is in writing. Without limitation, the Plan Administrator may designate other organizations or persons to carry out the following functions:

   a. Pursuant to an administrative services or claims administration agreement, the responsibility for administering and managing a Component Benefit Plan, including the processing and payment of claims thereunder and the recordkeeping related thereto.

   b. Responsibility to prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any government agency or to be prepared and disclosed to Employees, Participants or other persons entitled to disclosure under the Plan or any of its Component Benefit Plans.

   c. Responsibility to review claims or claim denials under any of the Component Benefit Plans, including discretionary authority to act as Claims Fiduciary and make Adverse Claims Determinations within the meaning of Department of Labor ("DOL") Regulation § 2560.503-1.

6) The authority to administer the Plan in compliance with Section 724 of ERISA, 29 U.S.C. § 1185m(a)(1)(B), which requires the Plan Administrator to share provider-specific cost or quality of care information or data to referring providers, the Plan Sponsor, Plan Participants, and Beneficiaries, or enrollees, or individuals eligible to become Participants, or Beneficiaries, or enrollees of the Plan, upon request. Upon receiving any such request, or if at any time the Plan Administrator requires access to the Plan's claims data for the purpose of fulfilling its obligations to administer the Plan and monitor Plan service providers, the Plan Administrator will work with the insurer or TPA providing access to a network of providers or pharmacies for a Component Benefit Plan to ensure the Plan or its designated business Employees have electronic access, on a per claim basis, subject to applicable privacy regulations, to all relevant claims and encounter information or data. This includes, on a per claim basis, financial information such as the gross charges, allowed amount, or any other claim-related financial obligations included in the provider contract; provider information, including name and clinical designation; service codes; and any other data element included in the claim or encounter transactions for which the data is requested. The Plan Administrator shall have unfettered access to its claims data at all times, in accordance with ERISA Section 724.

Subject to applicable law, any interpretation of the provisions of the Plan and the Component Benefit Plans, and any decisions on any matter within the discretion of and made by the Plan

Administrator in good faith shall be binding. A misstatement or other mistake of fact shall be corrected when it becomes known, and the Plan Administrator shall make such adjustment on account thereof as it considers equitable and practicable. The Plan Administrator shall not be liable for any determination of fact made in good faith.

IV. PLAN AMENDMENT OR TERMINATION

A. Right to Amend or Merge

Whoa & Co, Inc. expects to maintain the Plan indefinitely but reserves the right to amend the Plan and any of the Component Benefit Plans at any time or from time to time, in its sole discretion, including amendments that are retroactive in effect to the extent permitted by law. Any amendment may, at the determination of Whoa & Co, Inc., change, reduce, eliminate or otherwise affect benefits provided for under this Plan or any of the Component Benefit Plans, and no Participant, Dependent or Beneficiary has any vested right to benefits under the Plan or under any Component Benefit Plan. If you have elected to participate in the Plan, you will be notified in writing if there is any significant amendment to the Plan. Whoa & Co, Inc. reserves the right to merge the Plan or any Component Benefit Plan at any time in its sole discretion.

B. Right to Terminate

It is the intention of the Company that this Plan will be permanent. However, Whoa & Co, Inc. reserves the right to terminate the Plan, in whole or in part, at any time for any reason, including termination of any one or more of the Component Benefit Plans. Each of the Participating Companies reserves the right to terminate its participation in this Plan. In addition, any of the Participating Companies shall be deemed to terminate its participation in the Plan if: (i) it is a party to a merger in which it is not the surviving entity and the surviving entity is not an affiliate of another entity constituting the Company, or (ii) it sells all or substantially all of its assets to an entity that is not an affiliate of another entity constituting the Company or one of the Participating Companies. If you have elected to participate in the Plan, you will be notified in writing if the Plan is terminated. If the Plan is terminated, Whoa & Co, Inc. will cease deducting contributions from your salary to pay for benefits provided under the Plan.

C. Payment of Claims and Expenses Upon Termination

Upon termination, any assets remaining in the Plan shall be used to pay outstanding benefit claims. In the event of the Plan's termination, Whoa & Co, Inc. shall have no obligation under the Plan or Component Benefit Plans beyond paying the claims incurred (so long as such claims are filed within 90 days of the date the Plan is terminated) and expenses of the Plan incurred through the 90-day period in which claims may be filed.

V. ELIGIBILITY AND BENEFITS

An Employee (and that Employee's Spouse and Dependents, if applicable) is eligible to participate in the Plan only if and to the extent the Employee, Spouse or Dependent is eligible for the benefits provided under one of the Component Benefit Plans and the Employee makes the required contribution for the coverage selected. The Plan Administrator will inform you of the amount of the required Employee contributions, if any, for each type of coverage. The

following eligibility requirements apply to most of the Component Benefit Plans that comprise the Whoa & Co, Inc. Plan, although to determine whether you, your Spouse, or your Dependents are eligible to participate in a Component Benefit Plan, you should read the eligibility information contained in the applicable Component Benefit Plan Documents.

Employee Eligibility. Employees eligible for benefits include only those individuals who work full-time, at least 30 hours a week on a continuing and regular basis. Employees are eligible for most benefits on the first day of the month following 60 days of full-time employment. Part-time Employees and leased employees are not eligible to participate in the Plan.

Dependent Eligibility. A Dependent will be considered eligible for coverage on the date the Employee becomes eligible for coverage (on the first day of the month following 60 days of continuous full-time employment), subject to all limits and requirements in this Plan, the applicable Component Benefit Plan Documents, and under the following conditions:

1) newborn children of a covered Participant will be covered from the moment of birth, provided that enrollment for the child as a Dependent is requested within 30 days of the child's birth;
2) a new Spouse will be considered an eligible Dependent from the date of marriage, provided that enrollment of the Spouse as a Dependent is requested within 30 days of the date of marriage; and
3) if a Dependent is acquired other than at the time of birth due to a court order, adoption, placement for adoption or marriage, that Dependent will be considered an eligible Dependent from the date of the court order, adoption, placement for adoption or marriage, provided that enrollment of the new Dependent is requested within 30 days of such event.

A. ENROLLING IN THE PLAN

The Plan Administrator will establish procedures in accordance with each type of coverage for the enrollment of eligible Employees and their Dependents in the Component Benefit Plans and will communicate these procedures to eligible Employees. The Plan Administrator will prescribe the enrollment process that must be completed by a prescribed deadline prior to commencement of coverage under any of the Component Benefit Plans. See the specific Component Benefit Plan Documents for enrollment information, as the enrollment requirements may vary among benefit plans.

B. DISCRIMINATION BASED ON HEALTH-RELATED FACTORS PROHIBITED

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") prohibits health plans from discriminating against any Employee or Dependent in terms of eligibility to participate in the Plan based on a health-related factor. Accordingly, benefits provided under the Plan will be available to all similarly situated individuals. Any restriction on benefits will be applied uniformly to all similarly situated individuals and may not be directed at an individual based on a health-related factor. The Plan may (i) limit or exclude benefits that are experimental or are not medically necessary and (ii) require an individual to satisfy a deductible, copay, coinsurance, or other cost-sharing requirement in order to obtain a benefit, provided that all limits, exclusions, or cost sharing requirements apply uniformly to all similarly situated individuals and are not just directed at an individual based on a health-

related factor.

C. Special Enrollment Period

Once you are enrolled, you may make changes to your benefit plan elections only during open enrollment or if you have a change in status that affects the eligibility of you or your Dependents, *and* the requested election change corresponds with the effect on your eligibility (e.g. if an Employee gets married, they may add their Spouse to the Plan, subject to the enrollment provisions). Some changes in status that might qualify you or your Dependent(s) for special enrollment include:

1. Getting Married.
2. A new Dependent due to birth or adoption.
3. A change in *employment status* such as the termination of employment for your Dependent.
4. The receipt of a Qualified Medical Child Support Order ("QMCSO")
5. HIPAA Special Enrollment Opportunities:
   - Special enrollment opportunities when a current Employee or a current Employee's Dependent loses other coverage (coverage loss special enrollments)
   - Special enrollment opportunities due to birth, adoption, or placement for adoption of a child with a current Employee or a participant who is not a current Employee, or marriage of a current Employee or a participant who is not a current Employee (new Dependent special enrollments)
   - Special enrollment opportunities when a current Employee or a current Employee's Dependent loses Medicaid or CHIP coverage or becomes eligible for Medicaid or CHIP premium assistance (Medicaid and CHIP special enrollments)
6. Health Insurance Premium Payment (HIPP) is also an allowed change.

All election changes must be requested within 30 days of the event in question, with the exception of Medicare/Medicaid change (which must be requested within 60 days of the event in question) unless stipulated differently by state regulations or by carrier contract.

D. Proof of Dependent Eligibility

The Plan reserves the right to verify that your Dependent is eligible or continues to be eligible for coverage under the Plan's Component Benefit Plans. If you are asked to verify a Dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible Dependent continues without interruption, you must submit the required proof within the designated time frame. To make an election change, contact your Plan Administrator.

VI. CLAIMS AND APPEALS

A. Claims

A person entitled to benefits from a Component Benefit Plan is a "Claimant". All claims for benefits under the Plan and any assignment of benefits to a provider shall be made,

processed and paid, in accordance with DOL Regulations § 2560.503-1 and other applicable law, and the terms and conditions of the applicable Component Benefit Plan and the related provisions of the SPD for each Component Benefit Plan. The Plan Administrator shall be the Claims Administrator unless this function is delegated to another person or an insurance company, TPA, or other entity in the relevant Component Benefit Plan. The Plan Administrator reserves the right to overrule decisions of a delegated Claims Administrator when a determination is made that the Claim Administrator's decision was made in violation of ERISA, the terms of the Plan, including the terms of the applicable Component Benefit Plan, or the terms of any Component Benefit Plan Document.

B. No Estoppel or Waiver

No Participant or Beneficiary is entitled to any benefit under the Plan except and to the extent expressly provided under the terms and conditions of the applicable Component Benefit Plan. The fact that payments have been made from the Plan in connection with any claim for benefits does not (i) establish the validity of the claim; (ii) provide any right to have such benefits continue for any period of time; or (iii) prevent the Plan from recovering the benefits paid to the extent that the Claims Administrator determines that there was no right to payment of the benefits under the Plan. Thus, if a benefit is paid and it is thereafter determined that such benefit should not have been paid, regardless of fault, then the Claims Administrator may take such action as it deems necessary or appropriate to remedy such situation, including, without limitation, deducting the amount of any prior overpayment made to or on behalf of a Participant from any succeeding payments to or on behalf of the same Participant under the Plan, or from any amounts due or owing to the Participant by the Plan (offset), or otherwise recovering overpayment from whomever has benefited from it. If the Claims Administrator is an insurer or TPA under a Component Benefit Plan and refuses to recover an improperly paid benefit, the Plan Administrator reserves the right to do so.

If the Claims Administrator determines that an underpayment of benefits has been made, then the Claims Administrator shall take such action as it deems necessary or appropriate to remedy such situation.

C. Claims Procedures

The specific guidelines for filing a claim or a request for a review of a denied claim is set forth in detail in the Component Benefit Plan Documents. Such procedures shall comply with the general provisions of this Section and shall be designed to ensure the independence and impartiality of the persons involved in making decisions on such claims.

A Claimant must follow all internal claims and appeal procedures and, where applicable, all external review procedures before a lawsuit can be filed to contest an Adverse Benefit Determination. Failure to exhaust all of these procedures, also called administrative remedies, may result in a waiver of the claim.

D. Benefits Administered by Insurers and TPAs

Claims for benefits that are insured or administered by a TPA must be filed in accordance with the specific procedures contained in the Component Benefit Plan Documents. These procedures will be followed unless inconsistent with the requirements of ERISA as specified in this Wrap SPD. The name and address of the individual insurance company providing

benefits and reviewing claims relating to its insurance policy for a specific Component Benefit Plan or Program is set forth in Appendix B. Further, the name and address of the TPA that reviews claims made under a self-funded Component Benefit Plan is also set forth in Appendix B. All other general claims or requests should be directed to the Plan Administrator (*see* Section II).

E. Personal Representative

Claimants may exercise their rights directly or through an authorized personal representative. Claimants may only have one representative at a time assist with submitting an individual claim or appealing an Adverse Benefit Determination. A Claimant's personal representative may be required to produce evidence of his or her authority to act on Claimant's behalf. The Claims Administrator may require Claimant to execute a form relating to the representative's authority before the personal representative will be given access to protected health information ("PHI") or allowed to take any action on Claimant's behalf.

An assignment or attempted assignment of benefits does not constitute designation of an authorized personal representative. Such a designation must be clearly stated in a form understandable to the Claims Administrator. The authority of a personal representative may be proven by:

1. An executed power of attorney for health care purposes, properly notarized;
2. A court order appointing a person as the conservator or guardian of the Claimant; or
3. Proof that the personal representative is the parent of a minor child.

The Plan retains discretion to deny a personal representative access to a Claimant's PHI to provide protection to a vulnerable Claimant who depends on others to exercise his/her rights under these rules and who may be subject to abuse or neglect. Such access will only be denied for good cause shown. This also applies to personal representatives of minors.

F. Claimant's Rights When There is an Adverse Benefit Determination

If a claim for benefits is denied or ignored in whole or in part, and if Claimant has exhausted the claims procedures available under the Plan, Claimant may file suit in state or federal court. Claimant may also file a suit in federal court if Claimant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order. Any lawsuit filed in state court may be removed to federal court. Any legal action brought against the Plan must be filed no later than one year from the date the Claimant exhausted the claims procedures described herein.

Exhaustion of the Plan's claim and review procedures is a prerequisite to filing a lawsuit.

Where a dispute arises regarding a potential Beneficiary's right to payment of a benefit (such as a death benefit), the Claims Administrator may delay payment until the dispute is resolved. Resolution of the dispute may include the filing of an interpleader to obtain a judicial resolution.

The Plan's claims procedures are described below. These claims procedures do not apply to

any cafeteria plan which is a premium-only plan ("POP") or to the Dependent Care FSA.

G. Claims for Benefits Under a Component Benefit Plan

A request for benefits is a "Claim" subject to these procedures only if it is filed by a Claimant or the Claimant's authorized representative in accordance with the Component Benefit Plan's claim filing guidelines. In general, Claims must be made in writing (except urgent care claims, which may be made orally) with the Claims Administrator, which can be the Plan Administrator or the applicable Component Benefit Plan insurer or TPA. Review the Component Benefit Plan Documents for a specific Component Benefit Plan for more information.

The Claims Administrator for the relevant Component Benefit Plan will notify the Claimant of an Adverse Benefit Determination within a reasonable period of time, but not later than the time frame below, depending on the type of benefit being provided under the Component Benefit Program. An "Adverse Benefit Determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan, and including, with respect to a group health plan, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

H. Claim Denials Under A Component Benefit Plan That Is Not A Group Health Plan Or Disability Plan

The following procedures will be followed for claims that are denied under a Component Benefit Plan ***that is not*** a group health plan or disability plan. For group health claims and disability claims, see **Special Rules for Group Health Plan Claims** and **Special Rules for Disability Claims**.

1. If a claim is denied, Claimant will receive written notification within 90 days after the claim was submitted. Under special circumstances, the Claims Administrator may take up to an additional 90 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, Claimant will be notified before the end of the initial 90-day period of the circumstances requiring the extension and the date by which the Claim Administrator expects to render a decision.
2. The written notification of a denied claim for benefits will include the reasons for the denial, with reference to the specific provisions of the Component Benefit Plan on which the denial was based, a description of any additional information needed to process the claim, and an explanation of the claims review procedure. Failure to respond to a claim within 90 days will be treated as a denial, which may be overturned by the Claim Administrator if the failure to respond was done in error.
3. Within 90 days after notification of a claim denial, Claimant may appeal the denial

by submitting a written request for reconsideration of the claim to the Claims Administrator, which includes the reasons why Claimant believes the claim is valid and the reasons why Claimant believes the claim should not be denied. Before submitting an appeal request, Claimant may request to examine and receive copies of all documents, records, and other information relevant to the claim. If Claimant fails to file an appeal for review within 60 days of the denial notification, the claim will be deemed permanently waived and abandoned, and Claimant will be precluded from reasserting it under these procedures or in a court or any other venue.

4. Documents, records, written comments, and other information in support of the appeal should accompany any appeal request. The Claim Administrator will consider such information in reviewing the claim and provide, within 60 days, a written response to the appeal. This 60-day period may be extended an additional 60 days under special circumstances, as determined by the Plan Administrator or its delegate due to matters beyond its control. If an extension of time is required, Claimant will be notified before the end of the initial 60-day period of the circumstances requiring the extension and the date by which the Plan Administrator or its delegate expects to render a decision. The Plan Administrator's response, or the response of its delegate, will explain the reason for the decision with specific reference to the provisions of the Plan on which the decision is based, a statement that Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. The response will also contain a statement about Claimant's right to bring a civil action under ERISA Section 502(a).
5. Review the Component Benefit Plan Documents to determine whether the Claims Administrator has the discretion to interpret the appropriate Plan provisions, and whether such decisions are conclusive and binding, or whether the Plan Administrator retains final authority to interpret relevant Plan provisions and make final determinations of coverage.
6. To the extent not inconsistent with the provisions of the applicable Component Benefit Plan, a Claimant will be barred from bringing any civil action under the Plan after one year from the date of exhausting the Plan's claims procedures relating to the denial of a claim. In the case of a group health plan claim discussed below, the one year begins after Claimant exhausts the Plan's external claims procedure.

I. Special Rules for Group Health Plan Claims

For purposes of ERISA, there are four categories of claims under a group health plan, and each one has a specific timetable for approval, request for additional information, or denial of the claim. The four categories of claims are:

- **Urgent Care Claims**: A claim where failing to make a determination quickly could seriously jeopardize a Claimant's life, health, or ability to regain maximum function, or could subject the Claimant to severe pain that could not be managed without the

requested treatment. A licensed physician with knowledge of the Claimant's medical condition or an insurance company or TPA (applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine) may determine if a claim is an Urgent Care Claim.

- **Pre-Service Claims:** a claim for which Claimant is required to get advance approval or pre-certification before obtaining service or treatment for the medical services.
- **Post-Service Claims:** a request for payment for covered services Claimant has already received.
- **Concurrent Care Claims:** a request to extend an ongoing course of treatment beyond the period of time or number of treatments that has previously been approved under the Plan.

1. Time for Decision on a Claim.

The time deadline for making decisions on claims under the Plan depends on the category of the claim. Claimant will be notified of any determination on a claim (whether favorable or unfavorable) as soon as possible. If an Urgent Care Claim is denied, Claimant will be notified orally, and written notice will be provided to Claimant within three days.

Note that fully insured plan claims may be subject to an even more accelerated response time by the insurance company handling the claim. See the Component Benefit Plan Documents of the relevant Component Benefit Plan for specific response times.

If additional information is needed because necessary information is missing from the initial claim request, a notice requesting the missing information from Claimant will be sent within the timeframes shown in the chart below and will specify what information is needed. Claimant must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends a notice of missing information and the determination period will resume on the date Claimant responds to the notice.

Under special circumstances with respect to pre-service and post-service claims, the Claim Administrator may take up to an additional 15 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, Claimant will be notified before the end of the initial claim determination time period of the circumstances requiring the extension and the date by which the Claim Administrator expects to render a decision. The notice of extension that Claimant receive will include (i) an explanation of the standards on which entitlement to benefits is based; (ii) the unresolved issues that prevent a decision on the claim; and (iii) any additional information needed to resolve those issues.

2. Notification of Denial.

Except for Urgent Care Claims, when notification may be oral followed by written notice within three days, Claimant will receive written notice if the claim is denied. The notice will contain the following information:

(a) the specific reason or reasons for the Adverse Benefit Determination;

(b) reference to the specific Plan provisions on which the Adverse Benefit Determination was made;

(c) a description of any additional material or information necessary to perfect the claim and an explanation of why this material or information is necessary;

(d) a description of the Plan's review procedures and the time limits that apply to these procedures, including a statement of Claimant's right to bring a civil action under ERISA Section 502 if the claim is denied on review;

(e) a statement that Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;

(f) if an Adverse Benefit Determination is based on an internal rule, guidance, protocol, or other similar criteria, an explanation of those criteria or a statement that the criteria will be provided to Claimant free of charge upon request; and

(g) if the Adverse Benefit Determination is based on a medical necessity or experimental treatment limit or exclusion, an explanation of the scientific or clinical judgment on which such decision is based, or a statement that such explanation will be provided free of charge upon request of such person or persons who conducted the initial claim determination. The Plan Fiduciary will provide an independent full and fair review of the claim and will not give any deference or weight to the initial adverse determination. Claimant will receive a written notice of the decision on review.

3. How to Appeal a Denied Group Health Plan Claim.

If a claim is denied, Claimant, Claimant's attorney or Claimant's personal representative (see Section VI.E., above) will have 180 days following the date Claimant receives written notice of the denial in which to appeal such denial. If Claimant fails to file an appeal for review within 180 days of the denial notification, the claim will be deemed permanently waived and abandoned, and Claimant will be precluded from reasserting it under these procedures or in a court or any other venue. Unless Claimant is appealing the denial of an Urgent Care Claim, Claimant's request for review should be made in writing. Claimant may request review of an Urgent Care Claim orally or by facsimile. A request for review must contain Claimant's name and address, the date Claimant received notice the claim was denied, and Claimant's reason(s) for disputing the denial. Claimant may submit written comments, documents, records, and other information relating to the claim. Upon request, Claimant will be provided, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to the claim.

The period of time for the Claim Administrator to review an appeal request and to notify Claimant of its decision depends on the type of claim:

- **Urgent Care Claim:** 72 hours; Claimant will be notified orally and written notice will be provided within three days.

- **Pre-Service Claim**: 30 days if the Component Benefit Plan provides for only one mandatory appeal; 15 days for each appeal if the Component Benefit Plan provides for two mandatory appeals.

- **Post-Service Claim:** 60 days if the Component Benefit Plan provides for only one mandatory appeal; 30 days for each appeal if the Component Benefit Plan provides for two mandatory appeals.

The review will consider all comments, documents, records, and other information Claimant submits relating to the claim, without regard to whether that information was submitted or considered in the initial claim determination. The review will be conducted by a Plan fiduciary other than the person or persons (or a subordinate of such person or persons) who conducted the initial claim determination.

In addition, if the denial of the claim was based, in whole or in part, on a medical judgment in reviewing the claim, the Claim Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment in reviewing the claim. This person will not be a person, or a subordinate of a person consulted by the Claim Administrator in deciding the initial claim. The Claim Administrator will provide an independent full and fair review of the claim and will not give any deference or weight to the initial adverse determination. Claimant will receive a written notice of the decision on review. The notice will contain the following information:

(a) the specific reason or reasons for the denial;
(b) specific references to the pertinent plan provisions on which the denial is based;
(c) a statement that Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits (whether a document, record or other information is relevant to a claim for benefits shall be determined in accordance with the ERISA claims procedures;
(d) a statement, if applicable, describing any voluntary appeal procedures offered by the plan and Claimant's right to obtain information about such procedures, and a statement of Claimant's right to bring a civil action under Section 502(a) of ERISA following any final adverse benefit determination;
(e) a statement that a copy of any internal rule, guideline, protocol or other similar criteria relied upon in making the adverse benefit determination is available free of charge upon request;
(f) a statement that if a denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limit, the Claim Administrator will, upon request, provide Claimant, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the plan to Claimant's medical circumstances; and
(g) the following statement, if and to the extent applicable and required by law: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to

contact your local U.S. DOL Office and your State insurance regulatory agency."

Upon request, the Claim Administrator will provide Claimant with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

Time Limit (Group Health Plan Claims)	**Urgent Care***	**Pre Service***	**Post Service***
Initial claim determination	72 hours	15 days	30 days
Extension of time (with proper notice and if delay is due to matters beyond Plan's control)	None	15 days	15 days
Request missing information from Claimant	24 hours	5 days	30 days
Claimant to provide missing information	48 hours	45 days	45 days

***** The Claim Administrator will decide the appeal of "Concurrent Care Claims" within the time frame set forth above depending on whether the claim is (1) an Urgent Care Claim and the request to extend care is not made at least 24 hours prior to the scheduled expiration of treatment, (2) a Pre-Service Claim, or (3) a Post-Service Claim and before the expiration of any previously approved course of treatment. For an Urgent Care Claim that is a Concurrent Care Claim, if the request to extend care is made at least 24 hours prior to the scheduled expiration of the treatment, the initial claim determination will be made no later than 24 hours after such claim is filed with the Claim Administrator.

4. Special Internal Appeals Review Procedures Under the ACA.

Under the ACA, the following internal claims provisions apply to any "non-grandfathered," non-HIPAA-excepted coverage of the Plan based upon, generally whether the Plan is fully insured or self-funded for any Adverse Benefit Determination (i.e., any medical claim or any claim involving a rescission of coverage):

a) A rescission is allowed only upon a finding of fraud or intentional misrepresentation of a material fact;

b) Claimant must be provided with access to or a copy of, free of charge, any new or additional evidence considered, relied upon, or generated by the Claim Administrator in connection with the claim. The Claim Administrator must also provide Claimant with any new or additional rationale for a denial at the internal appeals stage as well as give Claimant a reasonable opportunity to respond to the new evidence or rationale;

c) Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual by a claims adjudicator or medical

expert may not be based on the likelihood that that person will support the denial of benefits due to that influence (for the purpose of avoiding conflicts of interest);

d) Notices to Claimants by the Claim Administrator must also include the following:

i. Any notice containing an Adverse Benefit Determination or final internal Adverse Benefit Determination must include information sufficient to identify the claim involved, including the date of the service, the health care provider, and the claim amount (if applicable) and state that, at Claimant's request, the diagnosis code and treatment code and their corresponding meanings will be provided as soon as practicable.

ii. Any notice containing an Adverse Benefit Determination or final internal Adverse Benefit Determination must include the denial code and corresponding meaning as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a final internal Adverse Benefit Determination, this description must also include a discussion of the decision.

iii. A description of all available internal appeals and the external review processes, including information about how to initiate an appeal at each level.

iv. The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman.

v. Notices of any Adverse Benefit Determination must be made in a culturally and linguistically appropriate manner, consistent with the DOL regulations, to any Claimant in the health plan who resides in a county in which ten percent or more of the population is literate only in the same non-English language as determined by guidance published by the DOL (a "10% Non-English County"). If Claimant resides in a 10% Non-English County, notices regarding the internal and external claims review must appear in both English and in the relevant non-English language. Furthermore, once a request has been made by a Claimant, all subsequent notices to such person ***must*** be in the applicable non-English language as well. The Claim Administrator must also provide oral language services in the non-English language (such as a telephone customer assistance hotline) to answer questions or provide Claimant assistance with filing claims and appeals.

e) In most cases, failure to adhere to the requirements of the ACA by the Claims Fiduciary will allow a Claimant to deem the internal claims and appeals process "not in compliance" with the ACA and to declare the Plan's claim procedure "exhausted" and to pursue any external review process or remedies available under ERISA or under state law, if applicable.

5. <u>Special State External Appeals Review Process Under the ACA.</u>

The DOL has given States a number of options to implement protections included in the external review process for any Adverse Benefit Determination that involves medical judgment (including, but not limited to, a determination regarding medical necessity,

appropriateness, health care setting, level of care or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational) or any claim involving a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at this time), relating to insured health benefits (and certain self-funded arrangements which have been allowed by State law to be subject to the State's review rules). Please refer to the external appeals table identified here: https://acacmsresources.com/r/appeals

6. Special Federal External Appeals Review Process Under the ACA.

Plans that are self-funded or have not elected/are not eligible to qualify for the State review external appeals process for any Adverse Benefit Determination are subject to the Federal review process described below.

a) Claimant will have four months after the day notice is received or are deemed notified of the final internal Adverse Benefit Determination to request an external review of any final internal Adverse Benefit Determination.

b) The Plan Administrator or Claim Administrator has five business days from the date a claim is made to complete a preliminary review and determine if the claim is eligible for external review (determining whether Claimant was covered at the time the service was provided), whether the appeal relates to a medical judgment, and whether the internal appeals process has been exhausted and all relevant information requested from the claimant was provided and, therefore, considered fully.

c) Within one business day after the preliminary review, the Plan Administrator or Claim Administrator will notify Claimant in writing of its decision. If the claim is complete but ineligible for external review, Claimant will be provided with the reason for its ineligibility and as well as contact information for the Employee Benefits Security Administration ("EBSA"). If the claim is incomplete, Claimant will be provided with an explanation of all necessary information needed to complete the claim, and Claimant must be provided with a reasonable time to complete the claim, such as the remainder of the four-month appeal period or, if later, at least 48 hours after the notice of incompletion.

d) If Claimant appeals an appealable final internal adverse benefits determination (or challenges its appealability), Claimant's claim must be referred to an Independent Review Organization ("IRO") accredited by URAC (formerly known as the Utilization Review Accreditation Commission) or by a similar reputable and recognized accrediting organization to conduct external reviews. The referral will occur through an unbiased selection process involving several IROs.

e) Once assigned to the IRO, the IRO must make a determination on a non-Urgent Care Claim within forty-five (45) days.

f) If the IRO reverses the decision of the Plan Administrator or Claims Fiduciary, Claimant's payments or coverage must begin immediately, even if the Plan Administrator or Claims Fiduciary expects to appeal the IRO's decision to a court of law.

g) All Claimants must have a right to expedited review for an Urgent Care Claim upon request. Once assigned to the IRO, the IRO must make a determination as quickly as possible, and in no event more than seventy-two hours (or forty-eight hours if the request was not in writing) after the IRO receives the request for expedited review.

h) The contracts between the Plan Administrator or Claims Fiduciary with the IROs must include the requirements set forth in the DOL Technical Releases, and the IROs must agree to: (a) *de novo* review of all information and documents timely received, including the Plan document, claims records, health care professional recommendations, and clinical review criteria used, if any, (b) retain its records for six (6) years and to make them available to the Claimant (or to State and Federal government agencies, to the extent not in violation of any privacy laws) for examination upon request, and (c) inclusion of certain information in notices to Claimants.

The Plan intends to act in good faith to comply with the claims and appeals rules under the ACA and the provisions herein should be interpreted accordingly.

7. External Review Under the No Surprises Act.

The No Surprises Act ("NSA"), part of the CAA, extended these external claims provision requirements to any Adverse Benefit Determination that involves consideration of whether a plan or insurer is complying with the NSA for both grandfathered and non-grandfathered plans.

J. Special Rules for Disability Claims

A disability claim requires the Plan to determine if a Claimant is disabled for purposes of eligibility for disability benefits under a Component Benefit Plan. Except as provided under this heading, the general claims procedures under the heading **General Claims Procedure** apply, including but not limited to the provisions relating to any Plan fiduciary's rights and responsibilities as provided in paragraph (c) under the **General Claims Procedure** and the claims limitation period identified in paragraph (d) under the **General Claims Procedure**.

1. drTime Limits for a Decision on a Disability Claim.

The Claim Administrator will notify Claimant of its determination within 45 days after receipt of a claim. This period can be extended for two (2) additional 30-day periods (up to a total of 105 days) if a decision cannot be made because of circumstances beyond the control of the Plan Administrator or Claims Fiduciary. If the Claim Administrator extends its period for reviewing a claim due to special circumstances, the notice of extension sent to Claimant must include an explanation of the standards on which the entitlement to benefits is based, the unresolved issues that prevent a decision on the claim and any additional information needed to make a claim determination. If more information is requested during either extension period, Claimant will have a minimum of 45 days to supply it.

2. Notification of Denial.

If a claim for disability benefits is denied, Claimant will receive a written notice of denial that sets out the information below in easy-to-understand language in accordance with 29 CFR 2560.503-1(o):

(a) The specific reason(s) for the Adverse Benefit Determination;

(b) Reference to the specific Plan provisions on which the determination was made;

(c) A description of any additional material or information necessary to perfect the claim and an explanation of why it is necessary;

(d) A description of the Plan's review procedures and the time limits that apply to such procedures, including a statement of Claimant's right to bring a civil action under ERISA Section 502(a) if the claim is denied on review;

(e) A discussion of the Adverse Benefit Determination, including an explanation of the basis for disagreeing with any of the following that apply:

i. The views presented by Claimant of health care professionals treating Claimant and vocational professionals who evaluated Claimant;

ii. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination, regardless of whether the advice was relied upon by the Plan Administrator or Claims Fiduciary that made the determination; and

iii. A disability determination made by the Social Security Administration ("SSA") regarding Claimant presented to the Plan;

(f) If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

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

(h) A statement that Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim.

3. How to Appeal a Disability Claim.

Claimant may appeal the Claim Administrator's determination within 180 days following receipt of an adverse determination in accordance with the procedures described in paragraph (c) under the heading **Special Rules for Group Health Plan Claims**. The Claim Administrator will notify Claimant of its determination on review within 45 days and in

accordance with the procedures in paragraph (b) under the heading **General Claims Procedure**. Otherwise, the general claims procedures apply, including the provisions relating to any Plan fiduciary's rights and responsibilities and the claims limitation period. Under special circumstances, the Claim Administrator may take up to an additional 45 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, you will be notified in writing before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Claim Administrator expects to render a decision. You have at least 45 days to provide the specified information.

4. Notification of Benefit Determination on Review.

Claimant will receive written notice of the Plan's benefit determination on review, which shall set out the information below in a culturally and linguistically appropriate manner in accordance with 29 CFR 2560.503-1(o):

(a) The specific reason or reasons for the benefit determination;

(b) Reference to the specific Plan provisions on which the benefit determination is based;

(c) A statement that Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;

(d) A statement describing any voluntary appeal procedures offered by the Plan and a Claimant's right to obtain the information about such procedures, and a statement of Claimant's right to bring an action under ERISA Section 502(a). This statement must include any applicable contractual limitations period that restricts a Claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;

(e) Where the determination is adverse, the notice must contain a discussion of the decision, including an explanation of the basis for disagreeing with *or* not following:

(1) The views presented by Claimant to the Plan of health care professionals treating Claimant and vocational professionals who evaluated Claimant;

(2) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and

(3) A disability determination made by the SSA about Claimant which was presented by Claimant to the Plan;

(f) If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(g) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Benefit Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

5. Additional Requirements for Disability Claims.

All claims and appeals for disability benefits must be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. As such, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) must not be made based upon the likelihood that the individual will support a denial of benefits.

Before a decision on review of a denied claim for disability benefits may be made, the Claim Administrator shall provide Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim. In addition, before a decision on review of a denied claim for disability benefits may be made based on a new or additional rationale, the Plan Administrator shall provide the claimant, free of charge, with the rationale.

Any new evidence or new rationale must be provided to Claimant as soon as possible and sufficiently in advance of the date on which a notice of Adverse Benefit Determination on review is required to be provided under applicable DOL regulations. This gives Claimant a reasonable opportunity to respond prior to that date.

6. Failure to Establish and Follow Reasonable Claims Procedures.

Failure to adhere to the requirements described in this Section, **Special Rules for Disability Claims,** will allow Claimant to deem the claims and appeals process non-compliant and exhausted, and the Claimant may proceed to pursue any remedies, including court action, available under ERISA. Notwithstanding the preceding sentence, any failure to adhere to the requirements described in this Section, whether through action or inaction, that is (i) de minimis, (ii) non-prejudicial to Claimant, (iii) attributable to good cause or matters beyond the Plan Administrator's or Claim Administrator's control, (iv) occurs in the context of an ongoing good-faith exchange of information, and (v) is not reflective of a pattern or practice of non-compliance, ***will not be considered non-compliant***. This paragraph will be interpreted and administered in accordance with 29 CFR 2560.503-1(1)(2).

VII. CONTRIBUTIONS, BENEFITS, SUBROGATION AND REIMBURSEMENT

A. Benefits

The Benefit Options provided under the Component Benefit Plans that make up this Plan are set forth in Appendix B hereto. The types and amounts of benefits available, the requirements for participation, and the other terms and conditions of the coverage and

benefits provided by each Component Benefit Plan are set forth in the Component Benefit Plan Documents.

B. Plan Contributions

The conditions of coverage, benefits, manner and time of payment and other provisions regarding the welfare benefits provided under the Plan are set forth in the Component Benefit Plan Documents. To the extent that Whoa & Co, Inc. self-insures the benefits and coverages, in full or in part, under the Plan, all benefits payable on behalf of the Participants that are self-funded by Whoa & Co, Inc. shall be paid from the general assets of Whoa & Co, Inc. and/or from Employees' contributions as specified in the Component Benefit Plan Documents. To the extent that coverages and benefits under the Plan through the Component Benefit Plans are provided through an Insurance Contract, all Employeed premiums shall be paid from Whoa & Co, Inc. general assets and Employees' contributions (if any) to such Insurance Company.

C. Subrogation, Reimbursement and Third-Party Recovery

If the Plan reimburses a Participant for medical or other expenses under this Plan (relating to Participant or anyone else deriving coverage through Participant, such as a Dependent) but later Participant recovers some or all of those expenses from a third-party, Participant is required to repay the Plan in full. The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

This could happen, for example, if Participant is in an automobile accident, where the Plan pays for hospital care, but later Participant makes a Claim against the other driver and recover for those same hospital expenses. This could also happen where some other person is responsible under contract or tort law for illness, injury, disease or some other condition suffered by Participant or anyone else deriving their coverage through Participant, such as medical error or malpractice, and Participant is compensated by reduction in the cost of a medical procedure.

By reimbursing Participant for medical or other expenses (either directly or through insurance), the Plan automatically acquires an equitable lien against any and all recovery that Participant gets from a third-party, and Participant is required to (and automatically agrees to) hold and account for any such recovery separately from Participant’s general assets, in constructive trust for the benefit of the Plan, so that the Plan’s right of recovery is unimpaired under ERISA and the rules of equity. Participant agrees not to take any action that could prejudice the Plan’s right of recovery. The so-called “make whole” rule does not apply except to the extent that the Plan Administrator, exercising discretion, chooses to apply it. Likewise, the “common fund” rule does not apply except to the extent that the Plan Administrator, exercising discretion, chooses to apply it.

Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and

all rights, recovery or causes of actions or claims that a Participant or Dependent may have against any third-party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, and even if the Participant or covered dependent has not been paid or fully reimbursed for all of their damages or expenses.

The Plan Administrator has discretion to enforce this provision by any necessary or appropriate means, which might include (a) withholding payment under the Plan until the outcome of Participant's Claim against the third-party is known, (b) making payment under the Plan but requiring Participant to sign a form pledging to repay the Plan to the extent of any recovery from a third-party, (c) making payment under the Plan but relying on this provision of the Plan to establish Participant's obligation to repay, (d) intervening in Participant's action against the third party in order to protect the rights of the Plan, (e) taking legal action against Participant for repayment, and (f) setting off Participant's obligation to repay against future benefits otherwise due under the Plan. The Plan's specific rights under each Component Benefit Plan to subrogation and reimbursement, including offset, are described in detail in the Benefits Booklets, Certificates of Coverage and SPDs attached to Appendix B.

VIII. MISCELLANEOUS PROVISIONS

A. Circumstances That May Cause Loss Of Benefits

The Plan contains numerous restrictions on the type and amount of benefits payable and the circumstances when paid. You should review the Component Benefit Plan Documents for further information. You could lose coverage under the Plan if Whoa & Co, Inc. terminates the Plan or amends it to reduce or eliminate your coverage. You could also lose coverage if you forfeit the right to benefits by, among other things:

- revoking your election to participate
- terminating employment with Whoa & Co, Inc.
- failing to make required contributions
- failing to file benefits claims on a timely basis, as defined herein, as well as by the claims filing time limits found in each Component Benefit Plan Document
- making fraudulent benefit claims
- ceasing to be an eligible Employee; or
- the Plan terminates.

B. Responsibility For Goods/Services

Whoa & Co, Inc. does not guarantee and is not responsible for the nature or quality of the goods or services provided through any health care provider or program because these goods and services are provided by personnel and agencies outside of the control of the

Company.

C. No Guarantee Of Employment

The Plan is not an employment contract. Nothing contained in this Wrap SPD nor the Component Benefit Plan Documents gives you the right to be retained in the service of Whoa & Co, Inc. or interferes with the right of Whoa & Co, Inc. to discharge you or to terminate your service at any time.

IX. COBRA

A. Continuation of benefits under COBRA

Qualified Beneficiaries shall have all continuation rights required by the Consolidated Omnibus Budget Reconciliation Act ("COBRA") for group health plan benefits offered under Welfare Programs. To the extent a Welfare Program offering health benefits does not specify COBRA Continuation Coverage rights in accordance with Code Section 4980B, the Plan shall be administered in accordance with Code Section 4980B and 29 CFR Part 2590.606-1 through 2590.606-4, with respect to the final COBRA notice rules and regulations for group health plans. In addition, the Plan Administrator shall adopt such policies and provide such forms, as it deems advisable to implement the rights contemplated by this Section.

B. Other Options

You may have other options available to you when you lose group health plan coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30- day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

C. Election of COBRA

1. <u>COBRA Continuation Coverage for Terminated Participants</u>.

In the event a Covered Employee, Qualified Dependent or Qualified Beneficiary experiences a Qualifying Event, the Plan Administrator shall provide notice of COBRA Continuation Coverage that shall inform such individual of their rights and obligations with respect to COBRA Continuation Coverage under the Plan.

A Qualified Beneficiary who is a Covered Employee may elect COBRA Continuation Coverage, at their own expense, if their participation under the Plan would terminate as a result of either of the following Qualifying Events:

- termination of employment (other than for gross misconduct); or
- reduction of hours of employment with WHOA & CO, INC..

2. <u>COBRA Continuation Coverage for Qualifying Dependent</u>.

A Qualified Beneficiary who is a Qualifying Dependent of a Covered Employee may elect COBRA Continuation Coverage, at their own expense, as follows:

(a) Qualifying Events for Dependent Spouses

- Voluntary or involuntary termination of the covered Employee's employment for any reason other than gross misconduct.
- Reduction in the hours worked by the covered Employee below plan eligibility requirements.
- Covered Employee becoming entitled to Medicare.
- Divorce or legal separation of the covered Employee (Spouse).
- Death of the covered Employee.

(b) Qualifying Events for Dependent Children

- Loss of Dependent child status under the plan rules.
- Voluntary or involuntary termination of the covered Employee's employment for any reason other than gross misconduct.
- Reduction in the hours worked by the covered Employee below plan eligibility requirements.
- Covered Employee becoming entitled to Medicare.
- Divorce or legal separation of the covered Employee.
- Death of the covered Employee.

A Qualified Beneficiary (or a third party on behalf of the Qualified Beneficiary) must complete and return the required COBRA election enrollment materials within a maximum of sixty (60) days from the later of:

- loss of coverage; or
- the date the Plan Administrator sends notice of eligibility for COBRA Continuation Coverage.

The Plan Administrator shall, in the event of a Qualifying Event that is either a Termination of Employment (other than for gross misconduct) or a reduction of hours, notify the Plan Administrator (or its designee) within thirty (30) days of the later of the date of the Qualifying Event or the date that coverage under the Plan ends. Such notice shall be given in a form and manner as determined by the Plan Administrator, in its sole discretion, in compliance with applicable law. The Plan Administrator shall then notify the Covered Employee and all covered Dependents of their right to elect COBRA Continuation Coverage within fourteen (14) days of such notice from the Plan Administrator.

Failure to enroll for COBRA Continuation Coverage during this maximum sixty (60) day period will terminate all rights to COBRA Continuation Coverage under this Plan and such right to COBRA Continuation Coverage shall not be reinstated. A separate election as to what health coverage, if any, is desired may be made by or on behalf of each Qualified Beneficiary. However, an affirmative election of COBRA Continuation Coverage by a Covered Employee or their Spouse shall be deemed to be an election for that Covered Employee’s Qualifying

Dependents who would otherwise lose coverage under the Plan, unless the election specifically provides to the contrary. Elections for COBRA Continuation Coverage may be made by the Qualified Beneficiary or on their behalf by a third party (including a third party that is not a Qualified Beneficiary). In the event the Plan Administrator determines that a Covered Employee, Qualified Dependent or Qualified Beneficiary who has furnished a notice of Qualifying Event, second Qualifying Event or disability determination is not entitled to COBRA Continuation Coverage, the Plan Administrator shall provide a notice of unavailability of COBRA Continuation Coverage to such affected individual in accordance with 29 CFR Part 2590.606-4(c).

D. Period of COBRA Coverage

A Qualified Beneficiary who qualifies for COBRA Continuation Coverage as a result of Termination of Employment (other than for gross misconduct) or reduction in hours of employment may elect COBRA Continuation Coverage for up to eighteen (18) months for termination or reduction in hours, and up to thirty-six (36) months for other qualifying events; certain states may impose longer continuation periods." With respect to all other Qualifying Events, a Qualified Beneficiary who is a Qualifying Dependent may continue COBRA Continuation Coverage for up to thirty-six (36) months from the date of the Qualifying Event.

A Qualified Beneficiary who properly elects and renders payment for the initial Continuation Coverage Contribution shall have such COBRA Continuation Coverage effective on the date of the Qualifying Event.

Coverage under this Section may be terminated early and may not continue beyond certain deadlines based on:

1. the date on which the Plan Administrator ceases to maintain a group health plan;
2. the last day of the month for which premium payments have been made, if the individual fails to make premium payments on time, in accordance with this Plan;
3. the date the Qualified Beneficiary, after the date they elect COBRA Continuation Coverage, first becomes enrolled in Medicare;
4. the date the Qualified Beneficiary, after the date they elect COBRA Continuation Coverage, first becomes covered under another group health plan and is no longer subjected to a pre- existing condition exclusion or limitation under the Qualified Beneficiary's other coverage or new Plan Administrator plan; or
5. in the case of a disabled Qualified Beneficiary (and their disabled or non-disabled family members) receiving COBRA Continuation Coverage under the eleven (11) month extended coverage extension, the first day of the month that begins more than thirty (30) days after the date the Qualified Beneficiary is determined by the SSA to no longer be "disabled" within the meaning of the Social Security Act.

In the event the Plan Administrator terminates COBRA Continuation Coverage of a Qualified Beneficiary prior to the end of the maximum available Continuation Coverage Period, the Plan Administrator shall provide a notice of such termination to each affected Qualified Beneficiary in accordance with 29 CFR Part 2590.606-4(d).

E. Contribution Requirements for Coverage

Qualified Beneficiaries who elect COBRA Continuation Coverage as a result of a Qualifying Event (or third parties on behalf of a Qualified Beneficiary) will be required to pay Continuation Coverage Contributions. Qualified Beneficiaries (or third parties on behalf of a Qualified Beneficiary) must make the Continuation Coverage Contributions monthly on or prior to the first day of the month of such coverage. However, a Qualified Beneficiary has forty-five (45) days from the date of an affirmative election to pay the Continuation Coverage Contributions for the first month plus the cost for the period between the date health coverage would otherwise have terminated due to the Qualifying Event and the date the Qualified Beneficiary actually elects COBRA Continuation Coverage. If the Qualified Beneficiary fails to make the Continuation Coverage Contribution for the first month's premium, coverage will either terminate or will be retroactively cancelled.

The Qualified Beneficiary shall have a thirty (30) day grace period from the due date (the first of each month) to make the Continuation Coverage Contributions due for such month. Continuation Coverage Contributions must be postmarked on or before the end of the thirty (30) day grace period. The thirty (30) day grace period shall not apply to the forty-five (45) day period for payment of COBRA premiums as applicable to initial elections.

If Continuation Coverage Contributions are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which such premiums were made on a timely basis. Once terminated, COBRA Continuation Coverage shall not be reinstated.

The Continuation Coverage Contribution shall be one hundred percent (100%) of the cost of coverage plus a two percent (2%) administrative fee for a total contribution of one hundred two percent (102%) of the cost of coverage.

If timely payment of the Continuation Coverage Contribution is made to the Plan in an amount that is not significantly less than the amount due for a period of coverage, then the amount paid is deemed to satisfy the Plan's requirement for the amount that must be paid for Continuation Coverage Contribution, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time (thirty (30) days) for payment of the deficiency to be made. For purposes of this Section of this Plan, an amount not significantly less than the amount the Plan requires to be paid shall be defined as the lesser of fifty dollars ($50) or ten percent (10%) of the required payment amount.

F. Limitation on Qualified Beneficiary's Rights to COBRA Continuation Coverage

If a Qualified Beneficiary loses, or will lose, health coverage under the Plan as a result of divorce, legal separation or ceasing to be a Dependent, such Qualified Beneficiary or the Covered Employee must notify the Plan Administrator within a maximum of sixty (60) days of the divorce, legal separation or loss of Dependent status. Such notice shall be required to comply with the Plan's notice procedures as contemplated by this Plan, in accordance with applicable law. Failure to make timely notification shall result in a termination of the Qualified Beneficiary's rights to COBRA Continuation Coverage under this Plan; such right shall not be reinstated.

A Qualified Beneficiary must notify the Plan Administrator of the birth to, adoption or placement for adoption of a child with a Covered Employee receiving COBRA Continuation Coverage. The notice must be provided within a maximum of thirty (30) days of the child's birth, adoption or placement for adoption with the Qualified Beneficiary, subject to the Plan's

notice procedures.

G. Extension of COBRA Continuation Coverage Period

If a second Qualifying Event that is not a Termination of Employment or reduction in hours occurs during an eighteen (18) month extension period explained above, coverage may be continued for a maximum of thirty-six (36) months from the date of the first Qualifying Event for the affected Qualifying Dependent. A second Qualifying Event will result in an extension of the initial Continuation Coverage Period if such Qualifying Event would have resulted in a loss of coverage under the Plan had the first Qualifying Event not occurred. Such extension of COBRA Continuation Coverage applies only to Qualifying Dependents. Therefore, such extension would apply to a child adopted by or placed for adoption with a Qualified Beneficiary but would not apply to a Spouse who was added to a Qualified Beneficiary's COBRA Continuation Coverage as a result of the Qualified Beneficiary's becoming married after commencement of the initial eighteen (18) month continuation period. Notwithstanding the foregoing, terminating employment after a Qualifying Event that is a reduction in hours of employment does not extend the maximum Continuation Coverage Period beyond eighteen (18) months of COBRA Continuation Coverage.

The maximum COBRA Continuation Coverage Period is extended up to eleven (11) months for Qualified Beneficiaries (and their disabled or non-disabled family members receiving COBRA Continuation Coverage due to the same Qualifying Event) for up to twenty-nine (29) months in total (measured from the date of the Qualifying Event), provided the following requirements are met:

1. the SSA determines that the Qualified Beneficiary was "disabled" on the date of the Qualifying Event or anytime within the first sixty (60) days of COBRA Continuation Coverage; and
2. the disabled Qualified Beneficiary provides evidence to the Plan Administrator of such SSA determination within sixty (60) days of the date of such determination but not later than the last day of the initial eighteen (18) month period of COBRA Continuation Coverage in a manner consistent with the Plan's reasonable notice procedures as contemplated by this Plan. Failure to notify the Plan Administrator of such determination within the time period stated above will result in the loss of the Qualified Beneficiary's right to an extension of the initial eighteen (18) month period of COBRA Continuation Coverage and such right will not be reinstated. In such event, if the disabled Qualified Beneficiary is receiving COBRA Continuation Coverage, the Continuation Coverage Contribution shall be one hundred fifty percent (150%) of the cost of coverage for the nineteenth (19th) through twenty-ninth (29th) month of COBRA Continuation Coverage. Otherwise, the Continuation Coverage Contribution shall continue to be one hundred two percent (102%) of the cost of coverage for the nineteenth (19th) through twenty-ninth (29th) months of coverage.

However, if a Qualified Beneficiary who meets the above requirements receives a final determination from the SSA that they are no longer disabled, the Qualified Beneficiary must notify the Plan Administrator within thirty (30) days of the date of that determination in a manner consistent with the Plan's notice procedures as contemplated by this Plan. Such a

final determination shall end the disability extension of COBRA coverage for all Qualified Beneficiaries as of the later of either: (i) the first day of the month following thirty days (30) from the final determination date or (ii) the end of the Continuation Coverage Period without regard to the disability extension.

H. Responses to Information Regarding Qualified Beneficiary's Right to Coverage

If a provider of health care (such as a physician, hospital, or pharmacy) contacts the Plan to confirm coverage of a Qualified Beneficiary during the COBRA Continuation Coverage election period, the Plan will give a complete response to the health care provider about the Qualified Beneficiary's COBRA Continuation Coverage rights during the election period, and his right to retroactive coverage if COBRA Continuation Coverage is elected. If a provider of health care (such as a physician, a hospital or pharmacy) contacts the Plan to confirm coverage of a Qualified Beneficiary with respect to whom the required payment has not been made for the current period, but for whom any applicable grace period has not expired, the Plan will inform the health care provider of all of the details of the Qualified Beneficiary's right to pay for such coverage during the applicable grace period.

I. Coordination of Benefits - Medicare and COBRA

For purposes of this Section, "Medicare Entitlement" means being entitled to Medicare due to either: (1) enrollment (automatically or otherwise) in Medicare Parts A or B, or (2) being medically determined to have end-stage renal disease ("ESRD"), and (a) having applied for Medicare Part A; (b) having satisfied any waiting period requirement and (c) being either (i) insured under Social Security, (ii) entitled to retirement benefits under Social Security or (iii) a Spouse or Dependent of a person satisfying either (i) or (ii). Such Medicare entitlement is a COBRA terminating event.

If you already have COBRA when you enroll in Medicare, your COBRA coverage usually ends on the date you enroll in Medicare. Your Spouse and Dependents may keep COBRA for up to 36 months, regardless of whether you enroll in Medicare during that time.

If you already have Medicare when you become eligible for COBRA, you will be allowed to enroll in COBRA subject to specific language in the Governing Documents.

J. Relocation and COBRA Coverage

If a Qualified Beneficiary moves outside the service area of a region-specific group health benefit package, alternative coverage, if available to similarly situated active Employees, will be made available to the Qualified Beneficiary no sooner than the date of the Qualified Beneficiary's relocation, or if later, the first day of the month following the month in which the Qualified Beneficiary requests the alternative coverage.

K. COBRA Coverage and HIPAA Special Enrollment Rules

Once a Qualified Beneficiary is receiving COBRA Continuation Coverage, the Qualified Beneficiary has the same right to enroll family members under HIPAA rules as if the Qualified Beneficiary were an Employee or Participant in the Plan, provided that such family members do not become Qualified Beneficiaries, and who are therefore eligible to elect COBRA Continuation Coverage in their own right.

Election of COBRA Continuation Coverage by a Qualified Beneficiary may serve to bridge

coverage between this Plan and any future coverage under another group health plan.

L. Procedures for Providing Notices

The Plan Administrator shall establish procedures for the furnishing of notices required by a Covered Employee, Qualifying Dependent or Qualified Beneficiary to the Plan Administrator and/or Plan Administrator including Qualifying Event notices, notice of disability determination or Medicare entitlement, change in disability determination, and Medicare entitlement. Such procedures may: be described in the Plan's Summary Plan Description; specify the individual or entity designated to receive such notices; specify the form and means of delivery of such notices (including requiring the use of certain forms when submitting such notices); describe the information required by the Plan to provide COBRA Continuation Coverage rights; and shall comply with applicable federal laws regarding requirements for timing and content of such notices. Moreover, the Plan Administrator may select or appoint another entity or individual to handle COBRA administration, where applicable.

M. COBRA Definitions

For purposes of this Section only, the following definitions shall apply:

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

"COBRA Continuation Coverage" means the coverage elected by a Qualified Beneficiary as of the date of a Qualifying Event. This coverage shall be the same as the health coverage provided to Similarly Situated Beneficiaries who have not experienced a Qualifying Event as of the date the Qualified Beneficiary experiences a Qualifying Event. If the provisions of this Plan are modified for Similarly Situated Beneficiaries, such coverage shall also be modified in the same manner for all Qualified Beneficiaries as of the same date. Open enrollment rights extended to active Employees will also be extended to Similarly Situated Qualified Beneficiaries.

"Continuation Coverage Contribution" means the amount of premium contribution required to be paid by or on behalf of a Qualified Beneficiary for COBRA Continuation Coverage.

"Continuation Coverage Period" means the applicable time period for which Continuation Coverage may be elected.

"Covered Employee" means an Employee covered under this Plan on the day prior to the Qualifying Event. If an individual who otherwise would be a Covered Employee is denied coverage under the Plan in violation of applicable law, including HIPAA, the individual is considered a Covered Employee.

"Annual Enrollment Period" means a period during which an Employee covered under the Plan can choose to be covered under another Plan or under another benefit option within the same plan or add or eliminate coverage of family members.

"Qualified Beneficiary" means a Covered Employee or Qualifying Dependent.

"Qualifying Dependent" means:

- a Covered Employee's Spouse or Dependent child covered under this Plan on

the day prior to the Qualifying Event; or

- a Dependent child who is born to, adopted by or placed for adoption with a Covered Employee during the Covered Employee's period of COBRA Continuation Coverage.

"Qualifying Event" means any of the following events which would otherwise result in a Covered Employee's or a Qualifying Dependent's loss of health coverage in the absence of this provision:

- a Covered Employee's Termination of Employment, for any reason other than gross misconduct;
- a Covered Employee's reduction in work hours resulting in a change of status such that the Covered Employee is no longer eligible to be a Covered Employee;
- a Covered Employee's divorce or legal separation;
- a Qualified Dependent ceasing to qualify as a Dependent under the provisions of this Plan;
- a Covered Employee's entitlement to benefits under Medicare;
- the death of a Covered Employee; or
- the failure of a Covered Employee to return from FMLA leave.

Loss of coverage includes any increase in the premium or contribution that must be paid by the Covered Employee (or Spouse or Dependent) for coverage under the Plan that results from the occurrence of one of the events listed above in subsections (i) – (vii). The loss of coverage need not occur immediately after the event, so long as the loss of coverage occurs before the end of the maximum COBRA Continuation Coverage period. If coverage is reduced or eliminated in anticipation of an event, such reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

"Similarly Situated Beneficiaries" means Employees or their Dependents, as applicable, who are Participants in this Plan.

X. STATUTORY PROVISIONS

A. Family and Medical Leave Act (FMLA)

To be eligible for FMLA leave, Employees must have worked for Whoa & Co, Inc. for a total of 12 months (which do not need to be consecutive) and for at least 1,250 hours in the previous 12 months, immediately preceding the leave. The 1,250-hour threshold can be met whether Employees work full-time or part-time. Whoa & Co, Inc. provides FMLA coverage to all

Employees, regardless of their geographic radius or number of Employees at each worksite.

If you go on a qualified unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), the following rules will apply. Only to the extent required by FMLA (among other things, this means only for the duration of a qualifying leave), the Plan Administrator will continue to maintain your health plan benefits on the same terms and conditions as though you were still an active Employee. Except as otherwise provided by FMLA, your Plan participation will cease when the Plan Administrator learns that you do not intend to return to work after your leave.

Your Plan participation will immediately cease upon expiration of your FMLA leave, if you fail to return to work at such time, unless otherwise required by federal, state, or local law. Except as otherwise provided in the FMLA, if you fail to return to work after the FMLA leave, you may be required to reimburse the Plan Administrator for the cost of the coverage provided to you while you were on FMLA leave (the cost equals the COBRA premium, without a 2% add-on, and minus any Employee contribution you already made). For more information on FMLA, please contact the Plan Administrator, where you may obtain a summary of your rights under FMLA without charge. The Plan Administrator has the responsibility to provide you with prior written notice of the terms and conditions under which payment must be made. Failure to make payment within 30 days of the due date established by your Plan Administrator will result in the termination of coverage.

If coverage is terminated for failure to make payments while you are on an approved Family or Medical Leave of Absence, coverage for you and your eligible Dependents will be automatically reinstated on the date you return to employment if you and your Dependents are otherwise eligible under the Plan. Any waiting period for pre-existing conditions or other waiting periods will not apply. However, all accumulated annual and lifetime maximums will apply.

The Plan intends to comply with all existing FMLA regulations. If, for some reason, the information presented differs from actual FMLA regulations, the Plan reserves the right to administer the FMLA in accordance with such actual regulations.

B. Military Leave Coverage

The Uniformed Services Employment and Reemployment Rights Act (USERRA) establishes requirements that Plan Administrators must meet for certain Employees who are involved in the uniformed services.

As used in this provision, "Uniformed Services" means:

- The Armed Forces;
- The Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (pursuant to orders issued under federal law);
- The commissioned corps of the Public Health Service; and
- Any other category of persons designated by the President in time of war or

national emergency.

As used in this provision, "Service in the Uniformed Services" or "Service" means the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes:

- Active duty;
- Active duty for training;
- Initial active duty training;
- Inactive duty training;
- Full-time National Guard duty;
- A period for which you are absent from your job for purpose of an examination to determine your fitness to perform any such duties;
- A period for which you are absent from your job for the purpose of performing certain funeral honors duty; and
- Certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

If you were covered under this Plan immediately prior to taking a leave for Service in the Uniformed Services, you may elect to continue your coverage under USERRA for up to 24 months from the date your leave for uniformed service began, if you pay any required contributions toward the cost of the coverage during the leave. This USERRA continuation coverage will end earlier if one of the following events takes place:

- You fail to make a premium payment within the required time;
- You fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service; or
- You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or less, your contribution amount will be the same as for active Employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage described above under the section entitled "COBRA".

If your coverage under the Plan terminated because of your Service in the Uniformed Services, your coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period(s) required by USERRA.

When coverage under the Plan is reinstated, all of the Plan's provisions and limitations will

apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by your military service, as determined by the Veterans Administration (VA). (For complete information regarding your rights under USERRA, contact your Plan Administrator.)

The Plan intends to comply with all existing regulations of USERRA. If, for some reason, the information presented in the Plan differs from the actual regulations of USERRA, the Plan reserves the right to administer the Plan in accordance with such actual regulations.

C. Leave of Absence Mandated Under State And Local Laws

The Plan may be required to maintain coverage for an Employee based on the provisions of applicable state or local laws. Such laws may allow Employees protected leave for various reasons such as sick leave, family leave, parental leave, domestic violence leave or other reasons mandated by state and local statutes.

D. Benefit Continuation Provisions For Non-Statutory Leave Of Absence

Coverage under the plan may be continued under the provisions of applicable Plan Administrator policy. The Plan may allow an Employee to remain covered when a leave of absence is needed for personal or medical reasons and when the Employee does not qualify for leave under statute such as FMLA or USERRA or state /local statute as noted above. There may be limits to the amount of time the Employee may remain on the plan as an active participant and after such time, the Employee may be offered continuation of coverage under federal COBRA or state continuation of coverage provisions. Continuation under this Section applies only to group health benefits; life, disability, and other welfare benefits are subject to the applicable Component Benefit Plan's terms.

E. Affordable Care Act

The Plan will also comply with stability rules under the ACA, where the Employee may still be able to maintain coverage under the plan outside of a leave of absence provided for under statute or under applicable Plan Administrator policy.

XI. HIPAA PRIVACY AND SECURITY

HIPAA also requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Component Benefit Plans' Privacy Notice or, if appropriate, in the privacy notice provided by the insurer. To obtain a copy of the privacy notice, contact the insurer or, if you have questions or complaints about the privacy of your health information, contact the Plan Administrator.

Neither this Plan nor Whoa & Co, Inc. will use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan requires all of its Business Associates and their subcontractors to execute written agreements that incorporate the privacy and security safeguards mandated by 45 C.F.R. §§ 164.502(e) and 164.308(b). These agreements ensure that all Business Associates use and disclose protected health information only as permitted by the Plan and HIPAA,

maintain appropriate safeguards, and report any unauthorized use or disclosure.

In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Whoa & Co, Inc.. Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan, your insurer, or with the Secretary of the U.S. Department of Health and Human Services ("HHS") if you believe your rights under HIPAA have been violated.

If a Health Benefit Program is not exempt from the requirements of the Privacy Standards and the Security Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), then this Section shall apply. The Plan also intends to comply with any applicable state laws relating to privacy and security.

A. Privacy and Security Standards

The Plan shall not disclose PHI to any member of the Plan Administrator's workforce unless each of the conditions set out in this Section are met. PHI shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment. PHI shall include "genetic information," as defined in the Privacy Standards. Electronic Protected Health Information ("EPHI") shall have the same definition as set out in the Security Standards, but generally shall mean PHI that is transmitted by or maintained in electronic media.

PHI disclosed to members of the Plan Administrator's workforce shall be used or disclosed by the Plan Administrator only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan treatment, payment functions and health care operations, including review of claims data and monitoring payment of claims. The terms "treatment," "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" shall include activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Genetic information shall not be used or disclosed for "underwriting" purposes, as defined in the Privacy Standards.

The Plan shall disclose PHI only to members of the Plan Administrator's workforce who are authorized to receive such PHI, and only to the extent and in the minimum amount necessary for that person to perform their duties with respect to the Plan. Members of the Plan Administrator's workforce means all Employees and other persons under the control of the Plan Administrator, including Plan Business Associates. The Plan Administrator shall keep an updated list of those authorized to receive PHI.

- An authorized member of the Plan Administrator's workforce who receives PHI shall use or disclose the PHI only to the extent necessary to perform their duties with respect to the Plan.

- In the event that any member of the Plan Administrator's workforce uses or discloses

PHI other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's Privacy Officer. The Privacy Officer shall take appropriate action, including:

- 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;
- 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;
- mitigation of any harm caused by the breach, to the extent practical; and documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

The Plan Administrator and all members of the Plan Administrator's workforce agree:

- Not to use or further disclose the PHI other than as permitted or required by the Plan documents or as required by law.
- To implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of EPHI that the Plan Administrator creates, maintains or transmits on behalf of the Plan.
- To ensure that any agent or subcontractor, (i) provided with PHI from the Plan agrees to the same restrictions and conditions that apply to the Plan Administrator with respect to such information, and/or (ii) provided with EPHI shall agree, in writing, to implement reasonable and appropriate security measures to protect the EPHI.
- Not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Administrator.
- Report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law.
- Make available PHI to individual Plan members as required by Section 164.524 of the Privacy Standards.
- Make available PHI for amendment by individual Plan members and incorporate any amendments to PHI as required by Section 164.526 of the Privacy Standards.
- Make available the PHI required to provide an accounting of disclosures to individual Plan members as required by Section 164.528 of the Privacy Standards.

- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards.

- If feasible, return or destroy all PHI received from the Plan that the Plan Administrator still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

- Ensure adequate separation between the Plan and members of the Plan Administrator's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above, and to use reasonable and appropriate security measures to comply with this provision.

B. HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this plan if you or your Dependents lose eligibility for that other coverage (or if the Plan Administrator stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 30 days after you or your Dependents' other coverage ends (or after the Plan Administrator stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. **You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.**

To request special enrollment or obtain more information, contact:

Leti Aguilar, Employee Benefits Contact
Whoa & Co, Inc.
1359 Rodalyn Drive
Boerne, TX 78006
(210) 695-9113 | accounting@eldridge-electric.com

XII. STATEMENT OF ERISA AND OTHER LEGAL RIGHTS

As a participant in the Plan (which is a type of Employee Welfare Benefit Plan called a "group health plan") you are entitled to certain rights and protections under ERISA and other applicable laws, which provide as follows.

A. Information About Your Plan and Benefits

all group health plan participants shall be entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest Annual Report

(Form 5500 Series) filed by the Plan with the U.S. DOL and available at the Public Disclosure Room of EBSA.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest Annual Report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

B. Continue Group Health Plan Coverage

all group health plan participants shall be entitled to continue health care coverage for yourself, and your Spouse and Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Spouse or Dependents may have to pay for such coverage. Review Section IX of this Wrap SPD and the Component Benefit Plan Documents on the rules governing your COBRA continuation coverage rights.

C. Medical Loss Ratio (MLR)

In certain circumstances under the Medical Loss Ratio Standards in section 2718 of the ACA, rebates may be paid to this Plan. The federal law requires that the issuer of the rebate (the insurance company) provide you a written notice of a rebate, at the time the rebate is paid to the Plan. The rebate will be prorated between the amount attributable to Plan costs paid by the Plan Sponsor and Plan costs paid by participants. The participant portion of the rebate will be used for the benefit of the Plan participants. This can be done by a number of actions, including but not limited to lowering the Plan costs for the participants for the next Benefit Plan Year, applied towards the cost of administering the Plan, paid as taxable income to the participants, or in any manner that allocates the rebate to Participants based on each Participant's actual contributions, or to apportion it on any other reasonable basis.

D. Qualified Medical Child Support Order Procedures

Qualified Medical Child Support Orders (QMCSO) is a court order, or an order issued by a state administrative agency, that specifically sets forth the rights of Dependents (children) to receive benefits under group health plans. An Employer must determine if it "qualified" to provide health insurance coverage to a participant's noncustodial child(ren). A "qualified" order must disclose the name, address of participant and any alternate recipient, the description of the type of health coverage to be provided, as well as how long it will be continued. Once this is determined, the coverage must be extended.

Whoa & Co, Inc. has established procedures for determining whether an order qualifies as a QMCSO. Participants' Dependents can obtain, without charge, a copy of such procedures from the Plan Administrator.

E. Telehealth and Direct Primary Care Safe Harbors

Effective for plan years beginning on or after January 1, 2025, and continuing thereafter, high-deductible health plans ("HDHPs") may provide first-dollar coverage for telehealth and other remote care services without affecting participants' eligibility to contribute to a health savings account ("HSA"). This permanent statutory safe harbor allows the Plan to choose, in its discretion, to waive the deductible for telehealth or other remote care services, whether or not such services are preventive or related to any particular condition.

In addition, the law provides a corresponding safe harbor for certain direct primary care ("DPC") arrangements, clarifying that participation in a qualifying DPC arrangement will not constitute disqualifying coverage for HSA purposes, and that certain DPC fees (within applicable IRS limits) may be treated as tax-qualified medical expenses under Internal Revenue Code § 213(d).

The Plan Administrator may elect to adopt either or both safe harbors, and may do so retroactively to the first day of the 2025 plan year to the extent administratively practicable. This paragraph supersedes all prior temporary relief provisions enacted under the CARES Act and the Consolidated Appropriations Acts of 2021, 2022, and 2023.

F. Transparency in Coverage Rule (TiC Rule)

The TiC Rule puts forth requirements for group health plans and issuers on the individual and group markets to disclose cost-sharing information, in-network provider negotiated rates, and historical out-of-network allowed amounts. This rule does not apply to grandfathered health plans, HIPAA-excepted coverage, healthcare sharing ministries or short-term limited duration insurance plans.

G. Medicaid

If a Health Benefit Program is subject to ERISA § 609(b), then this Section shall apply. Payment for benefits with respect to a participant under a Health Benefit Program will be made in accordance with any assignment of rights made by or on behalf of such participant or a beneficiary of the participant as required by a state plan for medical assistance approved under title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

The fact that a participant is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the SSA will not be taken into account in enrolling such Participant or in determining or making benefit payments for such Participant. To the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act in any case in which a Health Benefit Program has a legal liability to make payment for items or services constituting such assistance, payment for benefits under such program will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Participant to such payment for such items or services.

H. Newborn and Mothers Health Protection Act

Group Health Plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

I. Mental Health Parity and Addiction Equity Act

A Health Benefit Program that provides both medical and surgical benefits and mental health

and/or substance abuse benefits shall not impose any limits on mental health or substance abuse benefits that violate the requirements of ERISA § 712.

J. Michelle's Law

Michelle's Law allows continuation of group health coverage for up to one year for full-time students over the age of 26 who are Dependent children and who are on medically necessary leave of absence from post-secondary educational institutions.

K. Women's Health and Cancer Rights Act

If a Health Benefit Program is subject to ERISA § 713 and provides medical and surgical benefits with respect to a mastectomy, then this Section shall apply. Such Health Benefit Program shall, with respect to a participant who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with such mastectomy, provide coverage for the following (subject to applicable deductibles, copayments and other Health Benefit Program limitations):

1. reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. prostheses; and
4. treatment of physical complications for all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

This Plan complies with these requirements. Benefits for these items generally are comparable to those provided under this Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. The Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.

L. Patient Protection and Affordable Care Act Notice

If a Health Benefit Program is not exempt under ERISA § 732 from the requirements of Title I of the Patient Protection and Affordable Care Act of 2010, the Health Benefit Program shall be operated in accordance with such requirements.

If the Plans and issuers **require or allow for the designation of primary care providers** by participants or beneficiaries:

Plan Administrator's medical plan requires/allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the Plan or health insurance coverage designates a primary care provider automatically, until you make this designation, the Group Health Plan or health insurance issuer will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or issuer.

If the Plans and issuers require or allow for the designation of a **primary care provider for a child**; you may designate a pediatrician as the primary care provider.

If the Plans and issuers that provide coverage **for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider**:

You do not need prior authorization from the Group Health Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator or issuer.

M. Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your Plan Administrator, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for a Plan Administrator- sponsored plan.

If you or your Dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your Plan Administrator plan, your Plan Administrator must allow you to enroll in this Plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your Plan Administrator plan, contact the DOL at **www.askebsa.dol.gov** or call **1- 866-444-EBSA (3272)**.

N. Genetic Information Nondiscrimination Act

"GINA" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110- 233), which prohibits Group Health Plans, issuers of individual health care policies, and Plan Administrators from discriminating on the basis of genetic information.

GINA prohibits a Group Health Plan from adjusting group premium or contribution amounts for a group of similarly situated individuals based on the genetic information of members of the group.

O. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, 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 you and other Plan participants and beneficiaries. No one, including your Plan Administrator, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

P. Compliance with Future Law

The Plan shall be administered and interpreted in accordance with all applicable federal and state laws and regulations, as amended from time to time, including any interpretive guidance issued by the Departments of Labor, Treasury, and Health and Human Services. To the extent any provision of this Plan conflicts with such law, the Plan shall be applied and administered in a manner consistent with current legal requirements without the need for formal amendment.

XIII. INSTRUCTIONS FOR GROUP HEALTH PLANS

Federal law requires group health plans and health insurance issuers offering group or individual health insurance coverage to make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 9816 of the Internal Revenue Code (the Code), section 716 of the Employee Retirement Income Security Act (ERISA), and section 2799A-1 of the Public Health Service Act (PHS Act) apply, information in plain language on:

- the restrictions on balance billing in certain circumstances,
- any applicable state law protections against balance billing,
- the requirements under Code section 9816, ERISA section 716, and PHS Act section 2799A-1, and
- information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.

Plans and issuers may, but aren't required to, use this model notice to meet these disclosure requirements. To use this document properly, the plan or issuer should review and complete it in a manner consistent with applicable state and federal law. The Departments of Health and Human Services, Labor, and the Treasury (the Departments) will consider use of this model notice in accordance with these instructions to be good faith compliance with the disclosure requirements of section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, if all other applicable requirements are met.

If a state develops model language for its disclosure notice that is consistent with section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, the Departments will consider a plan or issuer that makes good faith use of the state-developed model language to be compliant with the federal requirement to include information about state law protections.

A. No Surprises Act

The No Surprises Act provisions of The Consolidated Appropriations Act (the "NSA") protect consumers from certain surprise medical billing that could arise from the following: (i) out-of network emergency care; (ii) certain ancillary services provided by an out-of-network provider at an in-network facility; or (iii) out-of-network care provided at in-network facilities without the patient's informed consent. If any of these events occur, the NSA protects participants from balance billing and only requires the in-network cost sharing amount to be paid. Providers will not be able to balance bill you and may not ask you to give up your protections not to be balance billed.

B. Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing.

C. What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

D. Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost- sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post- stabilization services.

E. Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't**

balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

F. When balance billing isn't allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the applicable entity responsible for enforcing the federal and/or state balance or surprise billing protection laws.

Visit www.dol.gov for more information about your rights under federal law.

XIV. DEFINITIONS

The following terms, where capitalized, shall have the meanings set forth below unless otherwise specified herein:

(1) **"Beneficiary"** means a Beneficiary under the Plan as defined under the terms of the respective Welfare Program.

(2) **"Benefit Plan Year"** means the twelve (12) consecutive month period commencing on July 1 of each year.

(3) **"Claims Administrator"** means the insurance carrier, third party administrator or other entity designated by the Plan Administrator to determine benefit eligibility and availability and/or pay claims for benefits under this Plan or a Component Benefit Plan under this Plan.

(4) **"Component Benefit Plan"** means any of the Component Benefit Plans being offered to Employees.

(5) **"Component Benefit Plan Documents"** means any description of benefits, certificate of coverage, subscriber agreement, or evidence of coverage booklet, and underlying service(s) agreements referenced by this SPD. These documents provide more details on specific items such as benefit coverage, definitions,

coordination of benefits, claims procedures, exclusions and limitations.

(6) **"Dependent"** means a covered Dependent under the Plan as defined under the terms of the respective Welfare Program.

(7) **"Effective Date"** means July 1, 2026.

(8) **"Employee"**

"Employee" shall mean a person who is an Employee of a Participating Company, who is actively at work, and regularly scheduled to work for the Participating Company in an Employer-Employee relationship. Such person must be scheduled to work an average of at least 30 hours per week in order to be considered an Eligible Employee for benefits. "Employee" shall not include any person classified on the Whoa & Co, Inc. records as other than an employee. For example, "Employee" shall not include anyone classified on the Whoa & Co, Inc. records as an independent contractor, agent, leased employee, contract employee, temporary employee or similar classifications. Coverage is offered to any Employee who is working full-time on a visa. Family member(s) that reside in the US with the Employee and have a valid social security number/documentation will be eligible for coverage if they meet the eligibility requirements of this Plan. Family members of the Employee who still reside in their home country are not eligible.

(9) **"Employer"** means Whoa & Co, Inc. or a Participating Company.

(10) **"Employer Contribution"** means contributions from the Employer.

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

(12) **"ERISA Plan Year"** means the twelve (12) consecutive month period commencing on July 1 of each year.

(13) **"Former Employee"** means any person formerly employed as an Employee of a Participating Employer.

(14) **"Fully Insured"** means a plan where the Plan Administrator contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs.

(15) **"Independent Review Organization" (IRO)** means a third-party organization contracted to collaborate in the decision-making process on claims.

(16) **"Insurer"** means Insurance Company that issues a particular insurance policy to an insured.

(17) **"Governing Document"** means the Plan Administrator agreement, the various insurance carrier plan documents and Component Benefit Plan Documents and this Summary Plan Description Wrap Document required by ERISA that include the Plan's terms for a number of items including eligibility, benefits, exclusions, a named fiduciary and Plan Administrator, claims and appeals procedures, funding information, and other items.

(18) **"Participant"** means an Employee or Former Employee of a Participating Company, and their eligible Dependents, who meets the requirements for eligibility as set forth in this Plan and who properly enrolls in the Plan. A person

shall cease to be a Participant when they no longer meet the requirements for eligibility.

(19) **"Participant Contribution"** means the contribution required to be paid by a Participant, if any, as determined under each Welfare Program. The term "Participant Contribution" includes contributions used to purchase insurance contracts or policies.

(20) **"Plan"** means this Plan, the Whoa & Co, Inc. Health and Welfare Benefits Plan, which consists of this Wrap SPD and each Component Benefit Plan and the Component Benefit Plan Documents, incorporated herein by reference, as amended from time to time.

(21) **"Plan Administrator"** shall have the same meaning as set forth in ERISA Section 3(16). The Plan Administrator for the Plan is:

Whoa & Co, Inc.
1359 Rodalyn Drive, Boerne, TX 78006
(210) 695-9113

(22) **"Plan Fiduciary"** means the same as the Plan Administrator. Notwithstanding, sometimes the Claims Administrator acts as a Plan Fiduciary, regardless of any limiting language in their Service Agreements saying otherwise.

(23) **"Plan Sponsor"** means Whoa & Co, Inc..

(24) **"Summary Plan Description (SPD)"** means this Wrap SPD as well as any Summary Plan Descriptions setting forth a summary of any of the Component Benefit Plans.

(25) **"Spouse"** means the legal Spouse (as defined by state law, as applicable) of a Participant.

XV. ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. You may also obtain a copy of *Your Rights Under ERISA* from the Employee Benefits Security Administration's website at https://www.dol.gov/agencies/ebsa

APPENDIX A – PARTICIPATING EMPLOYERS

The following employer participates in the Plan:

Whoa & Co, Inc. (d/b/a Eldridge Electric Company and Triple R Electric, Inc.)

EIN: 85-3285923 | 1359 Rodalyn Drive, Boerne, TX 78006 | Plan Sponsor

There are currently no affiliated companies or other Participating Employers whose employees participate in the Plan.

APPENDIX B – COMPONENT BENEFIT PLANS

Medical / Welfare Benefit	Benefit Type	Funding Type
Coastal Administrative Services, Inc. (TPA) – Medical Plan, Group No. 22501350	Medical	Self-Funded – Employer and Employee Contributions (stop-loss: Complete Captive Management Services, LLC)
US-Rx Care (PBM) – Prescription Drug, Group No. 22501350P2	Prescription Drug	Self-Funded – part of the Medical Plan
Innovative Care Management, Inc. – Utilization Review / Pre-Authorization	Medical – Care Management	Self-Funded – Plan administrative service
Dental – Mutual of Omaha, Policy No. G000ATAE	Dental	Fully Insured – Employee-Paid (Voluntary, Pre-Tax)
Vision – Mutual of Omaha, Policy No. G000ATAE	Vision	Fully Insured – Employee-Paid (Voluntary, Pre-Tax)
Basic Group Term Life – Mutual of Omaha, Policy No. G000ATAE ($130,000 Vice Presidents; $30,000 all other eligible Employees)	Life Insurance	Fully Insured – Employer-Funded
Basic Accidental Death & Dismemberment (AD&D) – Mutual of Omaha, Policy No. G000ATAE	Life Insurance – AD&D	Fully Insured – Employer-Funded
Voluntary Term Life and AD&D – Mutual of Omaha, Policy No. G000ATAE	Life Insurance / AD&D	Fully Insured – Employee-Paid (Voluntary)
Short-Term Disability – Mutual of Omaha, Policy No. G000ATAE	Disability – STD	Fully Insured – Employee-Paid (Voluntary)
Long-Term Disability – Mutual of Omaha, Policy No. G000ATAE	Disability – LTD	Fully Insured – Employer-Funded
Hospital Indemnity – Mutual of Omaha, Policy No. G000ATAE	Supplemental Health	Fully Insured – Employee-Paid (Voluntary)
Critical Illness – Mutual of Omaha, Policy No. G000ATAE	Supplemental Health	Fully Insured – Employee-Paid (Voluntary)

Accident – Mutual of Omaha, Policy No. G000ATAE	Supplemental Health	Fully Insured – Employee-Paid (Voluntary)

Insurer contact (all fully insured Component Benefit Plans): Mutual of Omaha, Dedicated Service Team – dfw.service@mutualofomaha.com. COBRA Administrator: Diversified Administration, Inc. – 954-983-9970 | cobra@div125.com.

ACCEPTANCE AND ADOPTION

By signing below, the undersigned authorized representative of Whoa & Co, Inc. (d/b/a Eldridge Electric Company and Triple R Electric, Inc.), as Plan Sponsor and Plan Administrator, hereby accepts and adopts this Wrap Plan Document and Summary Plan Description for the Whoa & Co, Inc. Health and Welfare Benefits Plan, including Appendices A and B, effective July 1, 2026, and certifies that it has been approved by all necessary corporate action.

WHOA & CO, INC.

Signature: Virginia Garver

Printed Name: Virginia Garver

Title: Controller

Date: 10/28/2026