Camunda, Inc. Employee Benefits Plan

Plan Document and Summary Plan Description

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Camunda, Inc.
Health and Welfare Plan

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Amended and Restated as of April 1, 2023, unless otherwise noted

The Plan Sponsor reserves the right to amend this Plan, in its sole discretion, at any time without the consent of any employee, former employee, or participant. The benefits provided under the Plan are not guaranteed benefits for covered persons or for their dependents. The Plan Sponsor reserves the right, in its sole discretion, to terminate the Plan or any Plan feature or component at any time and for any reason without liability.

The terms "you" and "your" as used in this document refer to an individual who is otherwise eligible to participate in the Plan. Receipt of this document does not guarantee that the recipient is in fact eligible to participate in the Plan or any Plan feature or component.

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Camunda, Inc.
Health and Welfare Plan

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Amended and Restated as of April 1, 2023, unless otherwise noted

This document, together with the provider contracts identified in Schedule A, and their respective policies, descriptions and other materials (either written or electronic), constitute the written plan and the summary plan description as required by Section 102 of the Employee Retirement Income Security Act of 1974 ("ERISA") and U.S. Department of Labor Regulation Sections 2520.102-2 and 2520.102-3 for the Camunda, Inc. Health and Welfare Plan (the "Plan").

The policies, contracts or booklets for each underlying Plan feature govern the benefits to be provided and include more details on how the Plan features operate. If there is any conflict between this plan document and such policies, contracts or booklets, then such other documents will control, unless otherwise specified herein. Participants and beneficiaries should not rely on any oral description of the Plan because the written terms of the Plan will always govern.

A. GENERAL INFORMATION ABOUT THE PLAN

This section contains general information that you may need to know about the Plan.

1. General Plan Information

The name of the Plan is the Camunda, Inc. Health and Welfare Plan.

The Plan Sponsor has assigned Plan Number 501 to the Plan.

The original effective date of the plan was January 1, 2021.

The Plan Year is the twelve-month period ending each December 31st.

The Plan includes the following Plan features:

- Group Medical Benefits (the "Group Medical Feature")
- Group Dental Benefits (the "Group Dental Feature")
- Group Vision Benefits (the "Group Vision Feature")
- Health Reimbursement Account (the "HRA Feature")
- Group Term Life (the "Group Term Life Feature")
- Group Long Term Disability Benefits (the "Group LTD Feature")
- Group Short Term Disability Benefits (the "Group STD Feature")
- Cafeteria Plan, which includes the health care flexible spending account.

2. Employer Information

The Plan Sponsor's name, address, and employer identification number are:

Camunda, Inc.
101 Montgomery Street Suite 1900
SAN FRANCISCO, CA 94104
E.I.N.: 38-3933355

3. Plan Administrator Information

The Plan Administrator's name and contact information is:

Camunda, Inc.
101 Montgomery Street Suite 1900
SAN FRANCISCO, CA 94104
Telephone: (415) 800-3908

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions you may have about the Plan.

4. Service of Legal Process

The name of the Plan's agent for service of legal process is:

Camunda, Inc.
101 Montgomery Street Suite 1900
SAN FRANCISCO, CA 94104

Service of legal process may also be made upon the Plan Administrator.

5. Type of Welfare Plan

The Plan is intended to be an "employee welfare benefit plan" within the meaning of ERISA Section 3(1).

6. Type of Administration

Benefits furnished under the Plan are administered by the providers from which benefits are purchased, or in the case of certain self-funded benefits, by the Plan Administrator (or a third-party administrator, as may be designated by the Plan Administrator from time to time). The name of each provider is set out in Schedule A. Unless otherwise indicated, all benefits furnished under the Plan are provided under the insurance policies, administrative contracts and/or plan documents identified in Schedule A, and the respective providers identified therein provide all necessary administrative services.

7. Amendment and Termination

The Plan Sponsor reserves the right to amend any one or more of the underlying Plan features or component benefits of the Plan at any time and for any reason, in its sole discretion, without the consent of any employee or former employee or participant. The benefits provided under the Plan are not guaranteed benefits for covered persons or for their dependents. The Plan Sponsor reserves the right, in its sole discretion, to terminate the Plan or any Plan feature at any time and for any reason, without liability. Upon the termination of the Plan or a Plan feature, as the case may be, all elections and reductions in compensation relating to the Plan or the applicable Plan feature will terminate.

The Plan may be amended or terminated by a written instrument duly adopted by the Plan Sponsor or any of its delegates. The Plan Sponsor may authorize one or more individuals to sign insurance contracts for this Plan on behalf of the Plan Sponsor, including amendments to those contracts, and such individual may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

B. ELIGIBILITY AND BENEFITS

1. Employee Eligibility Requirements

Subject to each Plan feature's eligibility requirements that are set forth in the provider contracts or other plan documents identified in Schedule A, and their respective policies, descriptions, plan materials and participant communications, all regular full-time and part-time employees of the Plan Sponsor are eligible to participate in the Plan upon date of hire, except for employees who are not regularly scheduled to work at least 30 hours per week.

To the extent that the Plan and/or a Plan feature's provider contracts and/or other plan documents refer to the eligibility of "employees," only individuals classified as "employees" by the Plan Sponsor are eligible to participate in such Plan feature. Independent contractors, freelancers and individuals hired through staffing firms shall not be eligible even if they are subsequently determined to be common law employees for any purpose, including without limitation, for wage, labor or tax purposes by the Internal Revenue Service, the Department of Labor or any other Federal or state agency, administrative body or court. Any

such determination should have a prospective effect only.

Certain Plan features require enrollment (either once or annually) for coverage. Information about enrollment procedures, including when coverage begins and ends for the various Plan features, is found in the attachments. An eligible employee begins participating in the Plan upon his or her election to participate in a Plan feature in accordance with the terms and conditions established for that feature or, if earlier, upon meeting the eligibility criteria and becoming covered under a Plan feature that does not require enrollment or an election.

Other individuals, such as Eligible Dependents may be eligible to participate in and receive benefits under one or more of the Plan features due to their relationship to an eligible employee. Information about such eligibility and coverage is found in the respective attachments.

NOTE: The Plan Administrator reserves the right to terminate your health care coverage prospectively without notice for cause (as determined by the Plan Administrator), or if you or a dependent are otherwise determined to be ineligible for coverage under the Plan. In addition, if you or your dependent commits fraud or intentional misrepresentation of a material fact (including, for example, in an application for health coverage under the Plan), in connection with a benefit claim or appeal, or in response to any request for information by the Plan Sponsor or its delegees (including the Plan Administrator or a claims administrator), the Plan Administrator may terminate your coverage retroactively upon 30 days' notice. Failure to inform any such persons that you or your dependent is covered under another group health plan (if required by the Plan) or knowingly providing false information in order to obtain coverage for an ineligible dependent are examples of actions that constitute fraud under the Plan. Coverage may also be terminated retroactively and without notice (unless required by law) if the Plan Administrator or its delegee determines that a spouse or dependent is ineligible for coverage under the Plan and such retroactive termination would not be considered a rescission under the Affordable Care Act. If coverage is terminated retroactively, you must reimburse the Plan and/or its delegee for the costs associated with providing coverage to any ineligible persons (including benefit claims, processing fees, administrative charges and all other costs), plus interest and any attorneys' fees incurred by them in order to collect such amounts. Additionally, you may be subject to further disciplinary action from the Plan Sponsor, including, but not limited to, termination of employment.

2. Dependent Eligibility Requirements

Subject to each Plan feature's eligibility requirements that are set forth in the provider contracts or other plan documents identified in Schedule A, and their respective policies, descriptions, plan materials and participant communications, you may also enroll the following members of your family in the Plan ("Eligible Dependents"):

a. **Your spouse**. "Spouse" means the individual to whom you are legally married as determined under federal law. The Plan Sponsor shall have the sole discretion to determine the legal status of a Participant's marriage for purposes of coverage under the Plan.
b. **Your children**. Each of your children who is:
    - under age 26, whether married or unmarried, regardless of his or her student or employment status and regardless of whether your home is his or her principal place of abode or whether you support him or her financially;
    - over the age of 26 and are unmarried and (i) primarily dependent on you for support because of a mental or physical disability; and (ii) for whom you give the Plan Sponsor satisfactory proof of such mental or physical disability within 31 days after the later of the commencement of such mental or physical disability or the date you first become an eligible employee under this Plan; or
    - for purposes of any Plan features that are subject to state-mandated benefits, over the age 26 to the extent required to be covered by such state law.

    For purposes of this definition, "Child" and "Children" means the following: your biological children, your legally adopted children, your stepchildren, children for whom you are appointed legal guardianship.

You may be required to verify the eligibility of your eligible dependents for coverage (e.g., by providing a birth or marriage certificate). If you fail to timely provide the documentation upon request to prove the eligibility of any of your eligible dependents or the Plan Administrator (or its delegee) is unable to verify the submitted documentation, your dependent (or dependents) will lose coverage under the Plan, whether or not they are otherwise eligible for benefits under the respective plan.

In order to enroll your eligible dependents in any Plan feature, you must also enroll in that coverage under the Plan. Unless your eligibility ends earlier, your eligible children will generally be covered under the Plan features that cover eligible children until the end of the month in which they reach age 26.

A note about Michelle's Law: To the extent that health coverage under a Plan feature of any dependent child over the age of 26 pursuant to a state-mandated benefit requires full-time student status, a dependent child includes the Employee's eligible dependent child as defined under Code section 152(f)(1) who is receiving health coverage as a full-time student in a post-secondary educational institution (including colleges and universities), and who would otherwise lose health coverage because he/she takes a medically necessary leave of absence that would cause the loss of student status, may be entitled to up to one year of continued coverage due to the medically necessary leave. In order to be eligible for this extension, the dependent child's treating physician must provide a written certification to the Plan Administrator that the child is suffering from a serious illness or injury and the leave of absence from the post-secondary institution is medically necessary.

c. **Your domestic partner**. To enroll your domestic partner and/or his or her eligible dependents, you and your domestic partner must:
* Be 18 years old;
* Not be barred from relations based on the degree of blood relation in the state in which they reside;
* Have lived together in a committed relationship for at least six consecutive months and expect to continue living together in a relationship in which they have joint and reciprocal financial responsibilities; and
* Not have a spouse or other domestic partner.
Additionally, the domestic partner cannot be independently eligible for coverage through the employer.

In addition, you must present two forms of documentation showing your shared financial responsibilities, such as:

- A joint lease or mortgage;
- A joint bank account statement;
- Joint ownership of a motor vehicle; or
- Designation of your partner as the primary beneficiary of your will, life insurance or retirement benefits.

3. Special Enrollment Rights

If you do not enroll yourself and your dependents in a group health plan after you become eligible or during annual enrollment, you may be able to enroll under the special enrollment rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") that apply when an individual declines coverage and later wishes to elect it. Generally, special enrollment is available if (i) you declined coverage because you had other health care coverage that you have now lost through no fault of your own (or employer contributions to your other health care coverage terminate); or (ii) you have acquired a new dependent (through marriage or the birth or adoption of a child) and wish to cover that person. When you have previously declined coverage, you must have given (in writing) the alternative coverage as your reason for waiving coverage under the group health plan when you declined to participate. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all eligible dependents in the group health plan if you provide notice to the Plan Administrator within 30 days after you lose your alternative coverage (or employer contributions to your alternative coverage cease) or the date of your marriage or the birth, adoption, or placement for adoption of your child.

You may also enroll yourself and your dependents in a group health plan if you or one of your eligible dependent's coverage under Medicaid or the state Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility, or if you or one of your eligible dependents become eligible for

premium assistance (that could be used toward the Plan costs) under a Medicaid or state child health plan under CHIP. Under these two circumstances, the special enrollment period must be requested within 60 days of the loss of Medicaid/CHIP coverage or of the determination of eligibility for premium assistance under Medicaid/CHIP.

The special enrollment rules do not apply to limited scope dental or vision benefits or certain health care flexible spending accounts (e.g., spending accounts that limit benefits to employee salary reduction amounts).

See the Plan Administrator for details about special enrollment.

4. Qualified Medical Child Support Orders

A Qualified Medical Child Support Order ("QMCSO") is an order by a court for a parent to provide a child or children with health insurance under a group health plan. The Plan Administrator (unless otherwise delegated) will comply with the terms of any QMCSO it receives, and will:

- Establish reasonable procedures to determine whether medical child support orders are qualified medical child support orders as defined under ERISA Section 609;
- Promptly notify you and any alternate recipient (as defined in ERISA Section 609(a)(2)(C)) of the receipt of any medical child support order, and the Plan's procedures for determining whether medical child support orders are qualified medical child support orders; and
- Within a reasonable period of time after receipt of such order, the Plan Administrator will determine whether such order is a qualified medical child support order and will notify you and each alternate recipient of such determination.

The Plan Administrator has developed procedures to determine whether a medical child support order is qualified and for complying therewith. You may obtain, without charge, a copy of these procedures upon request to the Plan Administrator.

5. Plan Benefits

The Plan provides for group medical benefits, group dental benefits, group vision benefits, health FSA benefits, health reimbursement account benefits, Group term life, group long term disability benefits and group short term disability benefits, all as more fully described (and subject to the limitations contained) in the provider contracts, plan documents and related materials referred to in Schedule A.

6. Loss of Benefits

As noted above, the Plan Sponsor reserves the right to change or eliminate any Plan feature under the Plan and may amend or terminate the Plan at any time. Except in the case of certain health care continuation rights under Federal law, or an applicable state law as described in the policies, contracts, booklets or other written materials for each underlying Plan feature, all benefits terminate at the end of the month that your active employment terminates or you are no longer eligible for benefits, or when the group insurance policy terminates, whichever occurs first. The Plan Administrator, in its sole discretion, reserves the right to suspend the termination of your benefits due to your loss of eligibility as a result of any declaration of a national or public health emergency.

When your participation in a component benefit program terminates, benefits under that component benefit program for you and your Eligible Dependents covered through you will cease. Termination of participation in a component benefit program occurs in accordance with the terms and conditions established for that program.

Benefits under all component programs (for all covered persons) will cease upon termination of the Plan.

Other circumstances can result in the termination of benefits. The insurance contracts (including the certificate of insurance booklets), plans, and other governing documents in the applicable Attachments provide additional information.

7. Plan Costs

Funding for Plan benefits is as described in Schedule A for each Plan feature. The dollar values of the participant contributions will be communicated to you prior to any initial, open, or special enrollment period. Upon the terms and conditions set forth in the Plan Sponsor's Flexible Benefits Feature, Participants may also elect to contribute to their health and/or dependent care flexible spending accounts.

C. NOTICES AND DISCLOSURES

1. Special Rule for Mothers' and Newborns' Coverage

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 attending provider or physician, 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Additional state laws may be applicable as more fully described in other materials detailing your medical benefits.

2. Special Rule for Women's Health Coverage

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires group health plans, insurance issuers and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and physical complications at all stages of mastectomy, including lymphedemas. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other medical or surgical benefits provided under the Group Medical Feature. For answers to specific questions regarding WHCRA benefits, contact the Plan Administrator. Additional state laws may be applicable as more fully described in other materials detailing your medical benefits.

3. Notice Regarding Lifetime and Annual Dollar Limits

In accordance with applicable law, any lifetime or annual dollar limits set forth in the Group Medical feature shall not apply to "essential health benefits," as such term is defined under Section 1302(b) of the Affordable Care Act. The law defines "essential health benefits" to include, at a minimum, items and services covered within certain categories including emergency services, hospitalization, prescription drugs, rehabilitative and habilitative services and devices, and laboratory services.

The restrictions regarding lifetime and annual dollar limits under the Group Medical Feature do not apply to services (even services for essential health benefits) which are limited by the number of visits or other criteria. For example, a medical plan may provide that coverage for a physical therapist is limited to up 30 visits per year per covered person.

4. Patient Protection Disclosure

If the Group Medical Feature in which you are enrolled requires the designation of a primary care provider, you have the right to designate any participating primary care provider who is available to accept you or your family members (for children, you may designate a pediatrician as the primary care provider). For information on how to select a primary care provider and for a list of participating primary care providers, contact the Plan Administrator. You do not need prior authorization from the Plan or from any other person, including your primary care provider, in order to obtain access to obstetrical or gynecological care from a health care professional; however, you 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.

5. Tax Notes

Domestic Partners. Federal law does not recognize "domestic partners" for specialized tax treatment under employer-sponsored group health plans. Unless your domestic partner and domestic partner's child(ren) are your federal tax dependents for group health plan purposes, you will be subject to federal (and possibly state) tax on the imputed value of the coverage provided to the domestic partner and the domestic partner's child(ren). You must notify the Plan Administrator if you believe your domestic partner meets the requirements for a federal tax dependent for group health plan purposes or a dependent under state tax law.

6. Mental Health Parity

With respect to any Plan features, if any, subject to the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the Plan provides parity between mental health and substance use disorder benefits and medical/surgical benefits with respect to financial requirements (e.g., deductibles, co-payments, coinsurance, and out-of-pocket maximums) and quantitative treatment limitations (e.g., number of treatments, visits, or days of coverage) or nonquantitative treatment limitations (such as restrictions based on facility type) under group health plans and health insurance coverage offered in connection with the Plan. Specifically, the Plan will not:

- Impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.
- Apply any financial requirement or treatment limitation (whether quantitative or nonquantitative) to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. The Plan Administrator will determine, in accordance with applicable regulations, the applicable mental health or substance use and medical/surgical benefit classifications.

Further, to the extent required by law, the Plan performs and documents comparative analyses of the design and application of its non-quantitative treatment limitations in accordance with applicable law.

Upon request and to the extent required by law, the Plan Administrator will:

- Make any criteria used to determine medical necessity for claims involving mental health or substance use disorder benefits available to current or potential Plan participants, as well as beneficiaries or in-network providers.
- Provide its comparative analyses of non-quantitative treatment limitations to Plan participants and their authorized representatives.

The manner in which these restrictions apply to the Plan will be determined by the Plan Administrator in its sole discretion in light of applicable regulations and other guidance.

7. No Surprises Act

The No Surprises Act of the Consolidated Appropriations Act, 2021 (the "CAA"), protects you from "surprise billing" or "balance billing" when you get emergency care at an out-of-network hospital or when you receive care from an out-of-network provider who is working at a hospital or ambulatory surgical center in your health plan's network.

A "balance bill" is a bill charged to you by an out-of-network provider or facility to make up the difference between what your health plan pays and the provider charges for the items or services rendered. "Surprise billing" is an unexpected balance bill you receive from a provider or facility. This can happen when you receive care from a facility that is in-network but one of the providers at the facility is out-of-network.

Under the No Surprises Act, you are protected from balance billing for emergency services provided by out-of-network providers, including services you may get after you are in stable condition (unless you give written consent and give up your protections against balanced billing for post-stabilization services).

You are also protected from surprise bills from services you receive from out-of-network providers while at an in-network hospital or ambulatory surgery center, such as services for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistance surgeon, hospitalist, or intensivist services. The most the providers can bill you is your in-network cost-sharing amount, and they can't ask you to give up your protections from being balance billed. If you receive other services at in-network facilities, out-of-network providers cannot balance bill you unless you provide written consent. Written consent can never be required. Further, you can always choose to get care at an in-network facility or from an in-network provider instead of getting care from an out-of-network provider or facility.

The Plan covers emergency services without requiring you to get approval for such services in advance, which is known as prior authorization. Further, the Plan covers emergency services even if those services are provided by providers who are outside the plan's network. Your required cost sharing (co-pays, coinsurance, or deductibles) for emergency care received by an out-of-network provider or facility will be the same as what you pay a provider or facility in the Plan's network. That amount will be included in your explanation of benefits. Finally, the amount of any cost-sharing you pay for emergency services or out-of-network services will count towards your applicable maximum annual deductible and out-of-pocket limits under the Plan.

Contact the Plan Administrator for more information.

D. RESPONSIBILITIES FOR PLAN ADMINISTRATION

1. Plan Administrator

It will be a duty of the Plan Administrator to ensure that the Plan is carried out, in accordance with its terms and in a nondiscriminatory manner, for the exclusive benefit of Participants and their beneficiaries in accordance with applicable law.

The Plan Administrator has (i) the power and authority in its sole, absolute and uncontrolled discretion to control and manage the operation and administration of the Plan and (ii) all powers necessary to accomplish these purposes.

The Plan Administrator will administer the Plan in accordance with established policies, interpretations, practices, and procedures and in accordance with the requirements of ERISA and other applicable laws. With respect to the Plan, the Plan Administrator has discretion (i) to interpret the terms of the Plan, (ii) to determine factual questions that arise in the course of administering the Plan, (iii) to adopt rules and regulations regarding the administration of the Plan, (iv) to determine the conditions under which benefits become payable under the Plan and (v) to make any other determinations that the Plan Administrator believes are necessary and advisable for the administration of the Plan. Subject to any applicable claims procedure, any determination made by the Plan Administrator will be final, conclusive and binding on all parties. The Plan Administrator may delegate all or any portion of its authority to any person or entity. For example, for benefits that are fully insured, the applicable insurance company is delegated certain administrative authority.

DESPITE ANY PLAN PROVISION TO THE CONTRARY, THE POLICIES, CONTRACTS OR BOOKLETS FOR EACH UNDERLYING PLAN FEATURE GOVERN THE BENEFITS TO BE PROVIDED, AND THE PROVIDERS FOR EACH PLAN FEATURE ARE RESPONSIBLE FOR MAKING BENEFIT DETERMINATIONS UNDER EACH SUCH PLAN FEATURE, NOT THE PLAN ADMINISTRATOR. IF THERE IS ANY CONFLICT BETWEEN THIS PLAN DOCUMENT AND SUCH POLICIES, CONTRACTS OR BOOKLETS, THEN SUCH OTHER DOCUMENTS WILL CONTROL.

2. Duties of the Plan Administrator

The Plan Administrator will (i) administer the Plan in accordance with its terms, (ii) decide disputes which may arise relative to a Plan participant's rights, (iii) keep and maintain the Plan documents and all other records pertaining to the Plan, (iv) pay or arrange for the payment of claims, (v) with respect to each group health plan covered under the Plan, establish and communicate procedures to determine whether a medical child support order is qualified under Section 609 of ERISA, and (vi) perform all necessary

reporting as required by ERISA.

3. Plan Administrator Compensation

   While the Plan Administrator serves without compensation, all expenses for administration, including compensation for hired services, will be paid by the Plan unless paid by the Plan Sponsor.

4. Fiduciary Duties

   A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the participants and their dependents and defraying reasonable expenses of plan administration. These duties must be carried out with the care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation and in accordance with Plan documents to the extent that they are consistent with ERISA.

5. The Named Fiduciary

   The Plan Administrator is a "named fiduciary" with respect to the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary will not be liable for any act or omission of such person unless either (i) the named fiduciary has violated its duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing to monitor the fiduciary or (ii) the named fiduciary breached its fiduciary responsibility under ERISA Section 405(a).

E. Uniformed Services Reemployment Rights

Your right to continued participation in a group health plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your plan participation will not be interrupted. If the absence is for more than 30 days and not more than 12 weeks, you may continue to maintain your coverage under a group health plan by paying premiums in the manner specified by the Plan Sponsor.

If you do not elect to continue to participate in a group health plan during an absence for military duty that is more than 30 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect continuation coverage under a group health plan for up to the 24-month period that begins on the first day of your leave of absence. You must pay the premiums for continuation coverage with after-tax funds, subject to the rules that are set out in the applicable Plan features.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

F. Leave under Family Medical Leave Act or Similar Law

If you take a leave of absence (i) for your own serious health condition, (ii) to care for family members with a serious health condition, (iii) to care for a newborn or adopted child, (iv) to care for an injured or ill covered service member of the Armed Forces, (v) due to a qualifying exigency arising out of a covered service member's active duty, or (vi) pursuant to any applicable law or regulation providing for similar leave as a result of a national or public health emergency, you may be able to continue your health coverage under the Plan. If you drop your health coverage during the leave, you can also have your health coverage reinstated on the date you return to work assuming you pay any contributions required for the coverage. See the Plan Administrator for more information about your FMLA rights.

G. Genetic Nondiscrimination

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of individuals or their family members. To comply with this law, the Plan Sponsor is asking you not to provide any genetic information when responding

to any request for medical information under the Plan. "Genetic information" that should not be disclosed pursuant to GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, genetic information of a fetus carried by an individual or an individual's family member, and genetic information of an embryo lawfully held by an individual or family member receiving assistive reproductive services.

H. COBRA

1. Introduction

The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. The following generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your COBRA rights and obligations under the Plan and under Federal law, you should ask the Plan Administrator.

The Plan Administrator is responsible for administering COBRA continuation coverage, but the Plan Administrator may delegate its administrative duties to a third party administrator from time to time. The Plan Administrator has delegated authority for administering COBRA continuation coverage to the following COBRA Administrator:

Health Equity
15 W. Scenic Pointe Drive #100
Draper, UT 84020
Telephone: (877) 722-2667

2. COBRA Continuation Coverage

COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." COBRA applies to each group health plan under the Plan. Specific qualifying events are listed later. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Federal law does not recognize your domestic partner as your spouse and a domestic partner is not recognized as a COBRA qualified beneficiary.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under a group health plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under a group health plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under a group health plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Each group health plan under the Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator (or third-party COBRA administrator, as applicable) has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or entitlement of the employee to Medicare (Part A, Part B, or both), the Plan Sponsor must notify the Plan Administrator (or third-party COBRA administrator, as applicable) of the qualifying event within 30 days of the date the event occurs or the date you would otherwise lose coverage under the group health plan due to a qualifying event, whichever is later.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator (or third-party COBRA administrator, as applicable). Each group health plan covered under the Plan requires you to notify the Plan Administrator (or third-party COBRA administrator, as applicable) within 60 days after the qualifying event occurs or the date you would otherwise lose coverage under the group health plan due to a qualifying event, whichever is later.

Within 14 days of the Plan Administrator (or third-party COBRA administrator, as applicable) receiving notice (in accordance with the procedures set forth below under "Furnishing Notice to Administrator") that a qualifying event has occurred, the Plan Administrator (or third-party COBRA administrator, as applicable) will send out an election notice, offering COBRA continuation coverage to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage under the group health plan would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. However, with respect to the extension of coverage under the healthcare flexible spending account of the Flexible Benefits Feature, continuation coverage will extend only until the end of the calendar year in which the qualifying event occurs.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under a group health plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator (or third-party COBRA administrator, as applicable) in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months.

You must make sure that the Plan Administrator (or third-party COBRA administrator, as applicable) is notified of the Social Security Administration's determination within 60 days of the latest of the date of the determination, the date of the qualifying event or the date you would otherwise lose coverage under the group health plan due to a qualifying event, and before the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, and such event would result in loss of health coverage if the first qualifying event had not already occurred, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, becomes entitled to Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible for coverage under the group health plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator (or third-party COBRA administrator, as applicable) is notified of the second qualifying event within 60 days of the second qualifying event or the date you would otherwise lose coverage under the group health plan due to a qualifying event, whichever is later.

Furnishing Notice to Administrator

Unless the Plan has a third-party COBRA administrator, in which case qualified beneficiaries should follow the notice procedures established by the third-party COBRA administrator, when furnishing a notice to the Plan Administrator with respect to the occurrence of a qualifying event or with respect to a disability determination by the Social Security Administration, such notices will be delivered to the human resources department of the Plan Administrator (i) by hand-delivery, (ii) via facsimile, followed by written confirmation by first class mail, or (iii) by registered or certified mail, return receipt requested. Such notices will include the name(s) of the covered employee and/or qualified beneficiaries, as applicable, a general description of, and circumstances surrounding, the qualifying event or disability determination, and the date of such qualifying event or disability determination. Once the Plan Administrator receives such notice, it reserves the right to make further inquiry to verify the circumstances surrounding such qualifying event or disability determination.

End of Continuation Coverage

Continuation coverage will end earlier than the period elected if:

- Timely payment of premiums for the continuation coverage is not made;
- The qualified beneficiary first becomes covered under any other group health plan, after the COBRA election, as an employee or otherwise;
- The qualified beneficiary first becomes entitled to benefits under Medicare, after the COBRA election;
- The Plan Sponsor ceases to provide any group health plan to any employee;
- You, as the covered employee, cease to be disabled, if continuation coverage is due to your disability; or
- The period of continuation coverage expires.

Health Insurance Marketplace

You may have other options available to you when you lose group health 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. For more information about the Marketplace, visit www.healthcare.gov.

Medicare

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends;
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to

pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you and https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Other Coverage Options

You may also be eligible for Medicaid or Children's Health Insurance Program (CHIP), which, if eligible, may be a coverage option in lieu of COBRA and may cost less than COBRA continuation coverage. You can learn more about these options at: www.healthcare.gov or https://www.healthcare.gov/medicaid-chip/childrens-health-insurance-program/.

If you have questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at www.dol.gov/ebsa.

Keep your plan informed of address changes

In order to protect your family's rights, you should keep the Plan Administrator (and third-party COBRA administrator, if applicable) informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices you send to the Plan Administrator (or third-party COBRA administrator, as applicable).

State COBRA Rights

If you are enrolled in an insured medical coverage, you may have health care continuation coverage rights provided by state law. Any state health care continuation benefits are provided by insurance companies and are not the obligations of the Plan Sponsor or this Plan. Contact your insurance carrier if you have any questions.

Conversion of Coverage

After your coverage and the coverage of Eligible Dependents would otherwise end under a Plan feature, you may have a right to purchase a conversion policy. For more information about whether a conversion right exists for a particular Plan feature, see the applicable attachments.

I. FUNDING POLICY

Benefits furnished hereunder are provided through the purchase of insurance policies and other provider contracts, unless otherwise indicated in Schedule A. The Plan Sponsor will collect any applicable employee premiums and will pay when due all premiums required to keep such policies and contracts in force. Funding is derived from the funds of the Plan Sponsor and any contributions made by the employees. To the extent you are required to make contributions toward the cost of a particular benefit feature, your contributions will be used in their entirety prior to using Plan Sponsor contributions to pay for the cost of such benefit. Accordingly, any claims experience dividends, refunds or other adjustments in premiums, fees or other Plan costs related to benefits provided under the Plan may be used to reduce the amount of contributions made by the Plan Sponsor. The level of any employee contributions is set by the Plan Sponsor, which will be communicated to you when you first

enroll in the Plan, and during each open and special enrollment period. The Plan Sponsor reserves the right to modify employee contribution amounts. Employee contributions will be used to fund, or reimburse the Plan Sponsor for funding, the cost of the Plan benefits as soon as practicable after they have been received from the employee or withheld from the employee's pay through payroll deduction.

J. SUBROGATION AND RIGHTS OF RECOVERY

The Plan is designed to only pay covered expenses under each Plan feature for which payment is not available from anyone else, including any insurance company or any other health or welfare plan. In order to help you and your covered dependents in a time of need, however, the Plan may pay covered expenses that may be or become the responsibility of another person, provided that the Plan later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the Plan, as well as by applying for payment of covered expenses, you and your dependents are subject to, and agree to, the following terms and conditions with respect to the amount of covered expenses paid by the Plan.

1. Assignment of Rights (Subrogation)

You and your dependents automatically assign to the Plan any rights (or causes of action) you and/or your dependents may have to recover all or part of the same covered expenses from any party, including an insurer or any other group health or welfare program, but limited to the amount of Reimbursable Payments made by the Plan. This assignment includes, without limitation, the assignment of a right to (or causes of action for) any funds paid by a third party to you and/or any of your dependents or paid to another for your benefit (or the benefit of one of your dependents). This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) you and/or one of your dependents constitute a full or a partial recovery, and even applies to funds paid for non-medical or non-disability charges, attorney fees, or other costs and expenses. This assignment also allows the Plan to pursue any claim that you and/or any of your dependents may have, whether or not you or such dependent chooses to pursue that claim. By this assignment, the Plan's right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage homeowner's plan, renter's plan, or any other insurance policy under which you or your dependents are insured.

The Plan will not be responsible for expenses or attorney's fees incurred by you or your dependents in connection with any recovery. Accordingly, you and your dependents must pay your own legal fees.

2. Equitable Liens/Equitable Remedies

The Plan shall also have an equitable lien against any rights (or causes of action) you and/or your dependents may have to recover the same covered expenses from any party, including an insurer or any other group health or welfare program, but limited to the amount of Reimbursable Payments made by the Plan. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

This equitable lien shall also attach to any money or property that is obtained by anyone (including, but not limited to, you or your dependent, your or your dependent's attorney, and/or a trust) as a result of an exercise of your and/or your dependent's rights of recovery (sometimes referred to as "proceeds"). The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the Plan Administrator, the Plan may reduce any future covered expenses otherwise available to you and/or your dependents under the Plan by an amount up to the total amount of Reimbursable Payments made by the Plan that is subject to the equitable lien.

3. Assisting Reimbursement Activities

You and your covered dependents have an obligation to assist the Plan to obtain reimbursement of the Reimbursable Payments that it has made on your behalf (and on behalf of your dependents), and to

provide the Plan with any information concerning your and/or your dependent's other insurance coverage (whether through automobile insurance, other group health or welfare program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits on your behalf (or on behalf of one of your dependents). You and/or your dependents are required to: (a) cooperate fully in the Plan's exercise of its right to subrogation and reimbursement; (b) not do anything to prejudice those rights (such as settling a claim against another party without including the Plan as a co-payee for the amount of the Reimbursable Payments and notifying the Plan); (c) sign any document deemed by the Plan Administrator to be relevant to protecting the Plan's subrogation, reimbursement or other rights; and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the Plan Administrator to enforce the Plan's rights.

Failure by you or your dependents to follow the above terms and conditions may result, at the discretion of the Plan Administrator, in a reduction from future benefit payments available to you or your dependents under the Plan of an amount up to the aggregate amount of Reimbursable Payments that has not been reimbursed to the Plan.

The Plan's rights hereunder shall not be construed to interfere or conflict in any way with the provisions of any insurance policies or other provider contracts that are made part of the Plan. Rather, the Plan's rights under this Section I shall run concurrent with any such similar right provided to any such insurer, vendor or provider under the Plan, but in no event shall you, or any of your dependents, as the case may be, be obligated to make payments to the Plan in excess of the Reimbursable Payments.

4. Recovery of Overpayments

Whenever a payment has been made under any Plan feature in a total amount, at any time, in excess of the maximum amount payable under the Plan's provisions ("Overpayment"), you or any other participant must refund to the Plan the applicable Overpayment and help the Plan obtain the refund of the Overpayment from another person or organization. This includes any Overpayments resulting from retroactive awards received from any source, fraud, or any error made in processing your claim.

In case of a recovery from a source other than the Plan, Overpayment recovery will not be more than the amount of the payment.

The Plan Administrator may, at its option, recover the Overpayment by reducing or offsetting against any future benefits payable under the Plan; stopping future benefit payments that would otherwise be due under the Plan (payments may continue when the Overpayment has been recovered); or demanding an immediate refund of the Overpayment.

K. PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan will not be construed as a contract for or of employment.

L. ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to

furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

2. 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 an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan participants. No one, including your employer 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.

3. Enforce Your Rights

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

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4. Assistance with Your Questions

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, including COBRA, HIPAA and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area 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 visit their website at www.dol.gov/ebsa.

M. Claims Procedure for the Plan

Except as provided in Paragraphs 1 or 2 below, claims for benefits under each Plan feature will be reviewed in accordance with procedures contained in the policies, contracts, summary plan descriptions or other written materials for such Plan features ("Component Documents"). However, all issues or disputes solely regarding eligibility for coverage or participation and all other general inquiries or requests should be directed to the Plan Administrator. If a non-insurance related claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the 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. If we fail to respond within 90 days, your claim is treated as denied. (This period may be extended to 180 days under certain circumstances.) Within 60 days after denial, if you want to appeal such denial, you or your beneficiary may

submit a written request for reconsideration of the application to the Plan Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Plan Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended to 120 days under certain circumstances.) In this response, the Plan Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Plan Administrator has the exclusive right to interpret the provisions of the Plan. Decisions of the Plan Administrator are final, conclusive and binding. The Plan Administrator has final claims adjudication authority under the Plan. However, the Plan Administrator may delegate duties and authority to others to accomplish those duties. For instance, the applicable administrator listed in the table in Schedule A is the claims administrator for the respective plan feature; each has sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the plan in which you are enrolled.

The insurer of each "insured" ERISA plan sponsored by the Employer has sole and complete discretionary authority to administer and interpret the provisions of the plan it insures. Please see the table in Schedule A to determine whether a plan is insured and for corresponding contact information for the applicable insurer or claims administrator.

Authorized Representatives

If you wish to designate an authorized representative to act on your behalf with respect to your claim for benefits, you must do so in writing. Please be advised that no rights under the Plan, including but not limited to the right to receive any benefit or any right to pursue a claim or cause of action, are assignable. Any payment by the Plan directly to a provider pursuant to a written election or purported assignments submitted by a participant or a dependent is provided at the discretion of the Plan Administrator as a convenience to the participant or dependent and does not imply an enforceable assignment of any benefits or the right to pursue a claim or cause of action.

1. Claims Procedure for Disability Benefits filed under the Plan

   The following claims procedure will apply specifically to claims made for disability benefits under one or more Plan features, including any rescission of disability coverage under such Plan features with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, rescission means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. To the extent that this procedure is inconsistent with the claims procedures contained in the policies, contracts, summary plan descriptions or other written materials for such Plan features, the claims procedures in such other policies, contracts, summary plan descriptions, or other written materials will supersede this procedure as long as such other claims procedures comply with DOL Regulation §2560.503-1.

   Timing of Adverse Benefits Determination

   If a claim under the Plan feature is denied in whole or in part, you or your beneficiary will receive written notification of the adverse benefit determination within a reasonable period of time, but no later than 45 days after the Plan Administrator's receipt of the claim. The Plan Administrator may extend this period for up to 30 additional days provided the Plan Administrator determines that the extension is necessary due to matters beyond the Plan Administrator's control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Plan Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Plan Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision. The extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information. The period from which you are notified of the additional required information to the date you

respond is not counted as part of the determination period.

Adverse Benefits Determination Notice

A denial notice will include:

- the specific reason(s) for your adverse benefit determination;
- reference to the specific Plan provision on which the determination is based;
- a description of any additional material or information necessary for you to fix your claim and an explanation of why such material or information is necessary;
- a description of the review procedures, including a statement of your right to bring a lawsuit following an adverse benefit determination on review;
- a discussion of the decision, including, an explanation of the basis for disagreeing with or not following:
    i. The views presented by the health care professionals treating you and vocational professionals who evaluated you;
    ii. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
    iii. A disability determination regarding you presented by you to the Plan made by the Social Security Administration;
- 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 your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. A document, record, or other information will be considered "relevant" to your claim if such document, record, or other information
    i. Was relied upon in making the benefit determination;
    ii. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
    iii. Demonstrates compliance with the administrative processes and safeguards designed to ensure and verify that benefit determinations are made in accordance with governing plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants; or
    iv. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

If you live in a county with a significant population of non-English speaking persons, the Plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.

Appeal Process

If you disagree with a claim determination, you can contact the Plan Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The subject individual's name and the identification number from the ID card, if any.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your appeal request must be submitted to the Plan Administrator within 180 days after you receive the claim denial.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

In addition, prior to the appeal determination noted below, the Plan Administrator will provide you, 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 as soon as possible and sufficiently in advance of the date on which the appeal determination is required to be provided to give you a reasonable opportunity to respond prior to that date. Before an adverse benefit determination on appeal based on a new or additional rationale, the Plan Administrator will provide you, free of charge, with the rationale; the rationale will be provided as soon as possible and sufficiently in advance of the date on which the appeal determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

Timing of Appeal Determination

You will be notified of the Plan Administrator's decision upon review within a reasonable period of time, but no later than 45 days after the Plan Administrator receives your appeal request. The 45-day period may be extended for an additional 45-day period if the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time. You will be provided with written notice prior to the expiration of the initial 45-day period. Such notice will state the special circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision.

Appeal Determination Notice

If denied, your review decision on appeal will include the following:

- the specific reason(s) for the adverse determination;
- reference to the specific Plan provision on which the benefit determination is based;
- a statement that you are entitled to receive, without charge, reasonable access to any document (i) relied on in making the determination, (ii) submitted, considered or generated in the course of making the benefit determination, (iii) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (iv) that constitutes a statement of policy or guidance with respect to the Plan concerning the claim without regard to whether the statement was relied on;
- either the specific rule or guideline used in making your benefits determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;
- if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the terms of the Plan to your medical condition, or a statement that such explanation will be provided without charge on request;
- a statement describing the Plan's optional appeals procedures, and your right to receive information about such procedures, as well as your right to bring a lawsuit and any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;
- a discussion of the decision, including, an explanation of the basis for disagreeing with or not following:
    i. The views presented by the health care professionals treating you and vocational professionals who evaluated you;
    ii. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

iii. A disability determination regarding you presented by you to the Plan made by the Social Security Administration.

If you live in a county with a significant population of non-English speaking persons, the plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.

Should the Plan fail to establish or follow ERISA required disability claims procedures, you may be entitled to pursue legal remedies under ERISA without exhausting your administrative remedies.

The Plan Administrator has the exclusive right to interpret the provisions of the Plan. Decisions of the Plan Administrator are final, conclusive and binding. The Plan Administrator has final claims adjudication authority under the Plan. However, the Plan Administrator may delegate duties and authority to others to accomplish those duties. For instance, the applicable administrator listed in the table in Schedule A is the claims administrator for the respective plan feature; each has sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the plan in which you are enrolled.

The insurer of each "insured" ERISA plan sponsored by the Employer has sole and complete discretionary authority to administer and interpret the provisions of the plan it insures. Please see the table in Schedule A to determine whether a plan is insured and for corresponding contact information for the applicable insurer or claims administrator.

2. Claims Procedures for a Group Health Plan

The following claims procedure will apply specifically to claims made under any group health plan covered under the Plan. To the extent that this procedure is inconsistent with the claims procedures contained in the policies, contracts, summary plan descriptions or other written materials for a group health plan covered under the Plan, the claims procedures in such other policies, contracts, summary plan descriptions, or other written materials will supersede this procedure as long as such other claims procedures comply with DOL Regulation §2560.503-1 and the Affordable Care Act.

Adverse Benefit Determinations

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Plan Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Plan Administrator will notify you within this 30- day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and hold your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Plan Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

Pre-Service Claims

Pre-Service Claims are those claims that require notification or approval prior to receiving health care. If your claim is a Pre-Service Claim, and it is submitted improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 5 days. If your Pre-Service Claim is submitted properly with all needed information, you will receive written notice of the claim decision from the Plan Administrator within 15 days of receipt of the claim. The Plan Administrator will notify you within this 15-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and hold your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Plan Administrator will notify you of the determination within 15 days after the

information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

Urgent Claims

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition, could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after the Plan Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you file an Urgent Care Claim improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim is received. If additional information is needed to process the claim, the Plan Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Plan Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The claims administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Adverse Benefits Determination Notice

A denial notice for a group health plan will include:

- the specific reason(s) for your adverse benefit determination;
- reference to the specific Plan provision on which the determination is based;
- a description of any additional material or information necessary for you to fix your claim and an explanation of why such material or information is necessary;
- a description of the review procedures, including a statement of your right to bring a lawsuit following an adverse benefit determination on review;
- either the specific rule or guideline used in making your benefits determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request;
- if the adverse benefit determination is based on a medical judgment, either an explanation of such judgment, or a statement that such explanation will be provided to you free of charge upon request; and
- in the case of an Urgent Care Claim, a description of the expedited review process to which you may be entitled.

In addition to the notice standards described above, to the extent required by the Affordable Care Act, all adverse benefit determination notices will include the following: (a) information identifying the claim involved, including the date of service, the health care provider, the claim amount, the diagnosis code, the

treatment code, and the corresponding meaning of those codes; (b) the reason or reasons for the adverse benefit determination that includes the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used to deny the claim (for notices of final internal adverse benefit determinations, the description will include a discussion of the decision); (c) a description of available internal appeals and external review processes, including how to initiate an appeal; and (d) contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist individuals with the internal claims and appeals and external review processes.

How to Appeal a Claim Decision

If you disagree with a claim determination, you can contact the Plan Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card, if any.
- The date(s) of health care service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Plan Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims, the first level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of Post-Service Claims, the first level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with Urgent Claims, see "Urgent Claim Appeals" below.

If you are not satisfied with the first level appeal decision of the Plan Administrator, you have the right to request a second level appeal from the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 60 days from receipt of first level appeal decision.

Please note that the Plan Administrator's decision is based only on whether or not benefits are available under the group health plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

Urgent Claim Appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your doctor should call the Plan Administrator as soon as possible, and provide the Plan Administrator with the information identified above under "How to Appeal a Claim Decision." The Plan Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

Appeal Determination Notice

If denied, your review decision on appeal will include:

- the specific reason(s) for the adverse determination;
- reference to the specific Plan provision on which the benefit determination is based;
- a statement that you are entitled to receive, without charge, reasonable access to any document (i) relied on in making the determination, (ii) submitted, considered or generated in the course of making the benefit determination, (iii) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (iv) that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;
- either the specific rule or guideline used in making your benefits determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request;
- if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the terms of the Plan to your medical condition, or a statement that such explanation will be provided without charge on request;
- a statement describing the Plan's optional appeals procedures, and your right to receive information about such procedures, as well as your right to bring a lawsuit; and
- the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If you file an internal appeal for medical benefits, you will continue to be covered pending the outcome of the internal appeal. This means that the Plan shall not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

Voluntary External Review

If the Group Medical Feature in which you are enrolled is not subject to a state external review process and:

- The plan either is a "grandfathered" or is not a "grandfathered" plan for purposes of the Affordable Care Act, and the adverse benefit determination involves a consideration of whether the Group Medical Feature is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act (Sections 2799A-1 and 2799A-2 of the Public Health Services Act) and implementing regulations; or
- The plan is not a "grandfathered" plan for purposes of the Affordable Care Act, and your internal appeal of a claim for benefits (not related to employee classifications or non-covered benefits, or compliance with the surprise billing and cost-sharing protections of the No Surprises Act) under such plan is denied;

You will have the right to request an external (i.e., independent) review if you do so within four months after receiving notice of an adverse benefit determination or final internal adverse benefit determination. Within five business days after receiving your request, a preliminary review will be completed to determine whether: (i) you are/were covered under the Plan; (ii) the denial was based on your ineligibility

under the terms of the Plan or whether the Plan is complying with the surprise billing and cost sharing protections of the No Surprises Act; (iii) you have exhausted the Plan's internal process, if required; and (iv) you provided all information necessary to process the external review. Within one business day after completing the preliminary review, you will be notified in writing if your appeal is not eligible for an external review or if it is incomplete. If your appeal is complete but not eligible, the notice will include the reason(s) for ineligibility. If your appeal is not complete, the notice will describe any information needed to complete the appeal. You will have the remainder of the four-month filing period or 48 hours after receiving the notice, whichever is greater, to cure any defect. If eligible for an external review, your appeal will be assigned to an independent review organization (IRO). If the IRO reverses the Plan's denial, the IRO will provide you written notice of its determination.

In addition, you will have the right to an expedited external review in the following situations:

- Following an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal.
- Following a final internal adverse benefit determination involving (i) a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or (ii) an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility.

The IRO will provide notice of its final external review decision as expeditiously as your medical condition or circumstances require, but not more than 72 hours after the IRO receives the request.

Limitation on When a Lawsuit May be Filed

All claim review procedures provided for in the applicable Component Documents must be exhausted (with the exception of the external review process, which is voluntary) before any legal action is brought. However, if you have requested an external review, you may not file a lawsuit until the external review process is concluded.

If you fail to file a request for review in accordance with the claims procedures outlined herein and in the Component Documents, you shall have no right of review and shall have no right to bring action in any court. The denial of the claim shall become final and binding on all persons for all purposes.

The Plan Administrator has the exclusive right to interpret the provisions of the Plan. Decisions of the Plan Administrator are final, conclusive and binding. The Plan Administrator has final claims adjudication authority under the Plan. However, the Plan Administrator may delegate duties and authority to others to accomplish those duties. For instance, the applicable administrator listed in the table in Schedule A is the claims administrator for the respective plan feature; each has sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the plan in which you are enrolled.

The insurer of each "insured" ERISA plan sponsored by the Employer has sole and complete discretionary authority to administer and interpret the provisions of the plan it insures. Please see the table in Schedule A to determine whether a plan is insured and for corresponding contact information for the applicable insurer or claims administrator.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan to be executed in its name and on its behalf this 1st day of June, 2023, unless otherwise noted, by a duly authorized officer of the Plan Sponsor.

Camunda, Inc.

DocuSigned by:

By Brittany Rohde

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Name: BRITTANY ROHDE

Title: SR DIRECTOR, PEOPLE OPS

Camunda, Inc.
Health and Welfare Plan

Schedule A

As of April 1, 2023, unless otherwise noted

I. Medical Plan

Carrier (fully insured)	Benefit Type	Contract/Group No.	Funding by
BlueCross Blue Shield of MA (800) 782-3675	Medical/RX	4960303	The cost of the benefit is shared by the Plan Sponsor and the employees.

II. Dental Plan

Carrier (fully insured)	Benefit Type	Contract/Group No.	Funding by
BlueCross Blue Shield of MA (800) 782-3675	Dental	4960303	The cost of the benefit is shared by the Plan Sponsor and the employees.

III. Vision Plan

Carrier (fully insured)	Benefit Type	Contract/Group No.	Funding by
Vision Service plan (VSP) PO Box 385018 Birmingham, AL 35238 (800) 877-7195	Vision	30101179	The cost of the benefit is shared by the Plan Sponsor and the employees.

IV. Health Care Flexible Spending Account

Claims Administrator (self-insured)	Benefit Type	Contract/Group No.	Funding by
Health Equity	HCFSA	5569006	The cost of the benefit is paid entirely by the participants.

V. Health Reimbursement Account (HRA)

Claims Administrator (self-insured)	Benefit Type	Contract/Group No.	Funding by
Health Equity	HRA	5569006	The cost of the benefit is paid entirely by the Plan Sponsor.

VI. Group Term Life

Carrier (fully insured)	Benefit Type	Contract/Group No.	Funding by
SunLife	Group Term Life	942995	The cost of the benefit is paid entirely by the Plan Sponsor.

VII. Long-term Disability

Carrier (fully insured)	Benefit Type	Contract/Group No.	Funding by
SunLife	LT Disability	942995	The cost of the benefit is paid entirely by the Plan Sponsor.

VIII. Short-term Disability

Carrier (fully insured)	Benefit Type	Contract/Group No.	Funding by
SunLife	ST Disability	942995	The cost of the benefit is paid entirely by the Plan Sponsor.

Schedule B - PARTICIPATING EMPLOYERS

As of April 1, 2023, unless otherwise noted

Each entity listed below has sufficient common ownership with the Employer so as to constitute a member of a commonly controlled group as described in Code §414(b), (c), (m), and (o) and has adopted the Plan with the consent of the Plan Sponsor.

None

Camunda, Inc.
Health and Welfare Plan

COVID-19 ADDENDUM

Pursuant to EBSA Disaster Relief Notices 2020-01 and 2021-01, and the Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak, certain deadlines pertaining to the Plan are disregarded until the earlier of: (a) one (1) year from the date (on or after March 1, 2020) that you are first eligible for relief; or (b) July 10, 2023 (unless the COVID-19 National Emergency anticipated end date of May 11, 2023 changes or is extended):

- The 30-day period (or 60-day period, if applicable) to request a HIPAA special enrollment;
- The 60-day election period for COBRA continuation coverage;
- The date/deadline for making COBRA premium payments;
- The deadline for individuals to notify the plan of a qualifying event or determination of disability;
- The deadline within which employees can file a benefit claim, or a claimant can appeal an adverse benefit determination, under the group health plan or disability plan claims procedures described in the Plan;
- The deadline for claimants to file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination; and
- The deadline for a claimant to file information to perfect a request for external review upon finding that the request was not complete.

NOTE: Absent a change to, or extension of, the anticipated end date of the COVID-19 National Emergency, after July 10, 2023, the above referenced time periods shall recommence, and no further extensions are required to be provided unless applicable law requires otherwise.

"COVID-19 National Emergency." The COVID-19 National Emergency means the March 13, 2020 Proclamation on Declaring a National Emergency Concerning the Coronavirus Disease 2019 (COVID-19) Outbreak issued by President Trump and President Trump's determination, under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121, et seq., that a national emergency exists as a result of the COVID-19 pandemic, as further extended in 2021 and 2022.