Holland Enterprises, Inc. Health and Welfare Benefit Plan

Plan Document

And

Summary Plan Description

Effective 04/01/2022

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ARTICLE 1. Definitions

The following words and phrases used herein shall have the following meanings, unless a different meaning is plainly required by the context. Masculine pronouns used in this Plan shall include masculine and feminine gender unless the context indicates otherwise, and words in the singular also include the plural. These are general definitions and the presence of any definition in this section is not, in and of itself, an indication of the existence of a benefit.

"**Cafeteria Plan**" means a cafeteria plan under Code Section 125 sponsored by the Company.

"**Claims Administrator**" means the entity or provider responsible for reviewing and approving insurance claims.

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

"**Code**" means the Internal Revenue Code of 1986, as amended.

"**Company**" means the entity or entities or any successor to it by merger, purchase or otherwise and any predecessor which has maintained this Plan or any corporation, sole proprietor, partnership or association that assumes the obligations of this Plan.

"**Component Benefit Programs**" are those benefit programs specified under Provider Companies and contained in previously provided documents, included with this document or available through the Plan Administrator.

"**Component benefit program or plan documents**" include certificates of insurance, group insurance contacts, ERISA plan documents (if self-funded) and governing benefit plan documents for non-insurance benefit programs.

"**Dependent**" means an Employee's Spouse or other dependent(s) that satisfies the dependent eligibility requirements of the applicable insurance plans.

"**Employee**" means any current or former employee of the Employer who satisfies the eligibility provisions as specified in the applicable benefit plans. The determination of whether an individual is an Employee, an independent contractor or any other classification of worker or service provider and the determination of whether an individual is classified as a member of any particular classification of employees shall be made solely in accordance with the classifications used by the Company and shall not be dependent on, or change due to, the treatment of the individual for any purposes under the Code, common law or any other law, or any determination made by any court or government agency.

“**Employer**” means the Company and any related employers who are participating under this Plan.

“**ERISA**” means the Employee Retirement Income Security Act of 1974, as amended.

“**Form 5500**”The Form 5500 Series is an important compliance, research, and disclosure tool for the Department of Labor, a disclosure document for plan participants and beneficiaries, and a source of information and data for use by other Federal agencies, Congress, and the private sector in assessing employee benefit, tax, and economic trends and policies. For employers required to submit form 5500 reports (usually 100+ participants on any group plan as of the beginning of the plan year), this document is considered a "wrap" plan so the report is done on the wrap plan as a whole, not each individual plan component benefit.

“**FMLA**” means the Family and Medical Leave Act of 1993, as amended. FMLA only applies to covered organizations with 50 or more employees within a 75 mile radius.

“**GINA**” means the Genetic Information Nondiscrimination Act of 2008.

“**HCERA**” means the Health Care and Education Reconciliation Act of 2010.

“**HIPAA**” means the Health Insurance Portability and Accountability Act of 1996, as amended.

“**HITECH**” means the Health Information Technology for Economic and Clinical Health Act.

"**Hour of service**" means (1) each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer, and (2) each hour for which an employee is paid, or entitled to payment, by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. Hours of service for all employees are credited using actual hours of service from records of hours worked and hours for which payment is made or due.

“**Insurer**” means any insurance company, health maintenance organization, preferred provider organization or any similar organization with whom the Company has contracted for an insured or contractually-established benefit.

“**MHPA**” means the Mental Health Parity Act of 1996.

“**MHPAEA**” means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act.

"New hire employee" means an employee who has been employed for less than one complete standard measurement period.

“**Named Fiduciary**” means the individual(s) or entity or entities responsible for either administering benefit plans or the insurance company providing coverage.

“**NMHPA**” means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

"**Ongoing employee**" means an employee who has been employed for at least one complete standard measurement period.

“**Participant**” means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan.

“**Plan**” means this employee benefit plan, which includes all benefits described in this document.

“**Plan Administrator**” means the person, the committee or the entity specified in this document to be the Administrator, as defined in ERISA Section 3(16)(A).

"**Plan Year**" means a twelve (12) month period specified in this document. The Plan Year also is the accounting period for the Plan.

“**Protected Health Information**” (“PHI”) is individually identifiable health information that is maintained or transmitted by a covered entity, subject to specified exclusions as provided in 45 CFR § 150.103.

“**PPACA**” means the Patient Protection and Affordable Care Act.

“**Spouse**” means an individual who is legally married to a Participant as determined under Revenue Ruling 2013-17 or otherwise defined in component plan documents.

“**Stability Period**” means a designated period of not less than six months (and not less than the corresponding measurement period) during which the employer must offer coverage to all individuals identified as full-time employees during the measurement period, regardless of hours worked during the stability period.

“**USERRA**” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

"Variable-hour employee" means a new employee if, based on the facts and circumstances at the employee's start date, the employer cannot determine whether the employee is reasonably expected to be employed on average at least 30 hours of service per week during the initial measurement period because the employee's hours are variable or otherwise uncertain. For purposes of determining whether an employee is a variable-hour employee, the

likelihood that the employee may terminate employment before the end of the initial measurement period will not be considered.

"**WHCRA**" means the Women's Health and Cancer Rights Act of 1998, as amended.

ARTICLE 2. Introduction

2.1 Introduction

This document contains a summary of your rights and benefits under Holland Enterprises, Inc. Health and Welfare Benefit Plan (the "Plan"). Complete details can be found in the underlying component benefit program documents which govern the operation of the Plan and are available with this document or through the Plan Administrator. In the event of any difference or ambiguity between your rights or benefits described in this document and the underlying component benefit program documents, the underlying component benefit program documents will control with regard to the specific benefits provided under the particular plan. For purposes of this document, component benefit programs are those benefit programs specified in Article 5, which can be found towards the end of this document, and contained in the applicable component plan documents. Component benefit program documents include certificates of insurance, group insurance contacts, ERISA plan documents (if self-funded) and governing benefit plan documents for non-insurance benefit programs.

A copy of each certificate, summary or other governing document is included with this document, was previously provided, or can be obtained from the Plan Administrator. Information contained in the underlying component benefit program documents defines and governs specific benefits including your rights and obligations for each plan. If you have any questions about this document or the component plan information, contact your Plan Administrator listed on the next page.

Each benefit option is summarized in component benefit program documents issued by providers, Third Party Administrators, or the Company. When the Plan refers to these documents, it also refers to any attachments to such contracts, as well as documents incorporated by reference into such contract (such as the application, certificate of insurance, ERISA plan documents and any amendments).

2.2 ERISA Status

This Plan Document and Summary Plan Description together with the applicable certificates of insurance, insurance booklets, benefit summaries and/or group insurance contracts constitute the written plan document required by

ERISA §402 and summary plan description for the component employee benefit plans offered under the plan, Holland Enterprises, Inc. Health and Welfare Benefit Plan.

The use of a trust account for any component benefit under the Plan maintained solely, expressly, and exclusively by an insurance carrier is intended to be unfunded pursuant to Technical Release 92-01. This trust account is not intended to create additional rights for participants or otherwise cause a component benefit or the Plan to be considered funded under ERISA.

For employers required to submit form 5500 reports (usually 100+ participants on any group plan as of the beginning of the plan year), this document is considered a "wrap" plan so the report is done on the wrap plan as a whole, not each individual component benefit.

ARTICLE 3. Plan Information

The following information concerns the Plan. If you need more information, contact the Plan Administrator.

NAME OF PLAN
Holland Enterprises, Inc. Health and Welfare Benefit Plan

EMPLOYER
Holland Enterprises, Inc.
500 Carl Olsen St.
Mapleton, ND 58059
701-373-7127

PLAN SPONSOR
Holland Enterprises, Inc.

PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER
45-0419854

PLAN SPONSOR'S COMPANY TYPE
Corporation

TYPE OF PLAN

This Plan provides comprehensive Medical, Dental, Vision, Life/AD&D, Health Reimbursement Arrangement (HRA) and Flexible Spending Account (FSA) benefit(s) and is considered a "Health & Welfare Benefit Plan" under ERISA.

Note: Dependent Care FSAs are not subject to ERISA and are included in this document for informational purposes only.

PLAN YEAR

April 1 through March 31

This plan year is applicable to the ERISA wrap plan and all policies included in the wrap plan, unless stated below.

Additional Policy Year(s)

The Health Reimbursement Arrangement (HRA), Health Flexible Spending Account (FSA) and Dependent Care FSA policy year is January 1 through December 31.

PLAN NUMBER

506

PLAN ADMINISTRATOR

Holland Enterprises, Inc.
500 Carl Olsen St.
Mapleton, ND 58059
701-373-7127
Attn: Karla Bancroft
karla@hollandent.com

CONTACT FOR SERVICE OF LEGAL PROCESS

Holland Enterprises, Inc.
500 Carl Olsen St.
Mapleton, ND 58059
701-373-7127

ASSOCIATED TRUST(S)

Trust for Medical Benefit

The name, title, and address of the trust and trustee(s) is:

Fargo-Moorhead Home Builders Health Plan & Trust (F-M HBHP&T)
Trustee of the F-M HBHP&T

Bryce Johnson, Plan Administrator
1802 32nd Avenue South
Fargo, ND 58103

3.1 Administration & Fiduciary

This document and the component plan documents describe the various benefits, whether each benefit is insured or self-funded, and Claims Administration and other services under the group benefit contracts.

For fully-insured benefits, the insurance company is the Named Fiduciary and has complete discretion to determine benefit payment amounts and to adjudicate claims. The Plan Sponsor has no fiduciary responsibility in these areas. See providers, policy numbers and their related contact information toward the end of this document.

For self-insured benefits under this Plan, the Plan Administrator may elect to use a Third Party Administrator (TPA) to administer these benefits and adjudicate claims. In such case, the Plan Administrator will be the Named Fiduciary but the TPA may be the Claims Administrator and the point of contact for questions.

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to interpret and construe the provisions of the Plan, to decide all questions that arise including any dispute which may arise regarding the rights of participants and beneficiaries under the Plan; provided, however, that if an insurance certificate sets forth a specific claims procedure, such provisions shall apply for the purpose of that component plan. It also is the Plan Administrator's duty to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, allocating fiduciary responsibilities, determining eligibility for and the amount of benefits, employing legal, actuarial, medical, accounting, clerical, and other assistance as it may deem appropriate in carrying out the terms of the Plan, and authorizing benefit payments and gathering information necessary for administering the Plan.

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

The Employer is a participating member of the Fargo-Moorhead Home Builders Health Plan & Trust (F-M HBHP&T). All funds comprising the assets of the Medical benefit are held in trust pending payment of benefits and/or administrative expenses. All Medical Plan benefits are paid or otherwise administered directly by the F-M HBHP&T pursuant to the Fargo-Moorhead Home Builders Health Plan & Trust Agreement (the "Trust Agreement").

The Plan Administrator delegates or assigns certain rights, duties, powers, and authority to the Trustee(s). These powers are described in the Trust Agreement. Copies of the Trust Agreement are available for review and may be obtained by contacting the Plan Administrator or Trustee.

Except as provided below, under "Power and Authority of Insurer or Third Party Administrator", the Plan Administrator has the discretionary authority to interpret the Plan in order to make benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

The Company will bear the incidental costs of administering the Plan. The Company may shift from time to time certain administration costs to Participants. The Company shall communicate to the Participants the details of any cost shifting arrangements.

Power and Authority of Insurer or Third Party Administrator

The Insurers or Third Party Administrator are responsible for:

(1) Determining the amount of any benefits payable under the respective component benefit program, and
(2) Prescribing claims procedures (that comply with ERISA requirements) to be followed and the claims forms to be used by Employees to obtain their respective benefits.

The Insurers, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the Insurers or Third Party Administrators for administering these program benefits.

For those component benefits under the Plan using a trust account, the Plan Administrator delegates or assigns certain rights, duties, powers, and authority to the Trustee(s). All assets of those component benefits are held in trust pending payment of benefits and/or administrative expenses by the Trustee pursuant to the Trust Agreement.

Exclusive Benefit

All Plan assets shall be used for the exclusive benefit of eligible Employees, their Spouses, their other designated Dependents and their designated beneficiaries, in accordance with the provisions of the Plan, and/or for paying reasonable expenses associated with administering the Plan.

3.2 Eligibility and Participation

Premium contributions for each of the health and welfare benefit plans provided by Holland Enterprises, Inc. are either attached to this document, given out separately or may be obtained from the Plan Administrator upon request.

Eligibility

Employee benefits begin as stated below, provided the employee meets the applicable requirements and satisfies the enrollment requirements established under the Plan.

Medical, Dental, Vision, Life/AD&D, Health Reimbursement Arrangement (HRA), and Flexible Spending Account benefit(s) begin on the first of the month following 60 days after date of hire. Employees must enroll in the Medical Plan benefit to be eligible for participation in the Health Reimbursement Arrangement (HRA).

Rehired Employees

The following rules only apply to applicable large employers or to small employers who have elected to establish Measurement and Stability Periods for Medical Insurance. Other benefits follow guidelines established in component plan documents.

An individual hired after a break in service of less than 13 weeks is considered a rehire for the purpose of benefit administration under the ACA. An individual with a break in service of more than 13 weeks (26 weeks in the case of an educational institution), is considered a new hire for the purpose of benefit administration. A returning Employee with a break in service of less than 13 weeks will be considered as continuing his or her employment.

Full-Time Ongoing and New Hire Employees – Eligibility and Participation

Full Time employees working 30 hours per week are eligible to participate in Medical, Dental, Vision, Life/AD&D, Health Reimbursement Arrangement (HRA), and Flexible Spending Account (FSA) Plan

benefits on the first of the month following 60 days after date of hire. Employees must enroll in the Medical Plan benefit to be eligible for participation in the Health Reimbursement Arrangement (HRA).

Once an Employee has met the eligibility requirements and an appropriate Enrollment Form has been submitted to the Plan Administrator, the Employee's coverage will commence on the date specified in the eligibility requirements at the beginning of this section and in the applicable component benefits program documents.

Eligible Family Members

You may also enroll eligible family members in the Medical, Dental, Vision, Life/AD&D, Flexible Spending Account, and Health Reimbursement Arrangement (HRA) plans. Eligible Dependents are generally described below but the governing eligibility rules for Dependents are set forth in the applicable component benefit plan documents.

Eligible family members include:

- Legal Spouse ("spouse" means an individual who is legally married to a participant as determined under Revenue Ruling 2013-17, in accordance with federal and state law and as specified in each benefit plan)
- Child (ren) up to age 26 or as defined in component plan documents; and/or
- Unmarried child (ren) of any age who depend upon the employee for support because of a mental or physical disability (For specified benefits only as defined in component plan documents).

Refer to underlying component benefit program documents for more information about Dependent eligibility, definitions of Dependents, and overall coverage. Your benefits eligibility may be affected if your status changes to inactive due to a family, medical, or personal leave of absence. Contact your Plan Administrator for additional information.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order, or QMCSO, is a medical child support order issued under state law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a

participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant is an alternate recipient.

With respect to component benefit programs that are group health plans, the Plan will also provide benefits as required by any qualified medical child support order (QMCSO) (defined in ERISA Section 609(a)). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

In the event the Plan Administrator receives a qualified medical child support order, the Plan Administrator will notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a QMCSO. Within a reasonable period, the Plan Administrator will determine whether the order is a qualified medical child support order and will notify the Participant and alternate recipient of such determination.

Furlough & Short-term Leave

In the event that the company elects to implement a furlough, where some employees' hours are reduced to zero or below the minimum required hours for participation, they may be eligible to continue participation in the group medical plan during the furlough time up to an amount determined by the component plan documents and insurance providers. If employees are impacted by furloughs, they will be provided additional details regarding the furlough, continuation of medical insurance, and premiums.

3.3 Annual Open Enrollment Period

Each year Holland Enterprises, Inc. has open enrollment period(s) where participants can make plan changes or new participants can enroll. Changes and elections made during the open enrollment period are generally effective (upon plan renewal) following the open enrollment period. Contact the plan administrator for more information regarding the date and/or duration of the open enrollment period(s).

3.4 Enrollment in the Plan

Enrollment Procedures

An Employee who is eligible to participate in this Plan shall commence participation after the eligibility requirements have been satisfied, provided that any enrollment forms are submitted to the Plan Administrator before

the date that participation would commence. Such enrollment forms shall identify the Spouse and other Dependents who are eligible for benefits under the elected benefit plan.

Certain benefits require that an eligible Employee make an annual election to enroll for coverage. Information regarding enrollment procedures, including when coverage begins and ends for the various benefits under the Benefit options, is set forth in the certificate of insurance, component Summary Plan Descriptions or other governing documents. An eligible Employee may begin participating in any benefit based on his or her election to participate in accordance with the terms and conditions established for each benefit.

Mid-Year Enrollment Changes (Only if Qualified Change in Status)

If benefits are paid on a pre-tax basis through a Cafeteria Plan, legal rules require that benefit choices made must remain in effect for the entire Plan Year (or the balance of the Plan Year for Employees hired and who enroll during the Plan Year), unless the Employee experiences a Qualified Change in Status. While the list of possible events that could allow you to make mid-year election changes is set by the IRS and the Internal Revenue Code, Holland Enterprises, Inc. and its Insurance Carriers or Third Party Administrator can select a sub-group of these events to allow changes under a particular plan. Under the Code you must enroll within a reasonable time period from your eligibility date. Once you are enrolled, you may only make changes to your benefit elections during Open Enrollment or if you have a Qualifying Change in Status that affects the eligibility of you or your dependents, and the requested election change is consistent with your Qualifying Change in Status.

The following are examples of what might be considered a Qualifying Change in Status, refer to your Cafeteria Plan for an accurate list of qualifying events.

A Qualifying Life Event/Qualifying Change in Status includes:

- A change in your Legal Marital Status such as marriage, death of a spouse, divorce, legal separation or annulment.
- A change in your Number of Dependents such as birth, adoption, placement for adoption, or death of a child.
- A change in Employment Status such as commencement or termination of employment for you, your spouse, or your dependent.
- A change in Work Schedule such as a reduction or increase in hours, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence for you, your spouse, or your dependent.

- If Dependent Satisfies or Ceases to Satisfy the Requirements for Dependents due to factors such as age.
- A change in Residence or Worksite for you, your spouse, or your dependent.
- The receipt of a Qualified Medical Child Support Order or National Medical Support Notice.
- A change in Entitlement to Medicare or Medicaid for you, your spouse, or your dependent.
- A change in Eligibility for COBRA for you, your spouse, or your dependent while you are still an active employee.
- A change in a spouse's coverage such as benefit reduction, cost increase or decision to join or not to join a plan during open enrollment.
- A change where an Employee may qualify for exchange coverage because the employer coverage does not meet the affordability requirements.
- An Employee may drop coverage if their hours drop below 30 hours/week on average, even if the Employee does not lose eligibility for coverage due to Affordable Care Act rules on eligibility.

All election changes must be requested within 30 days of the event in question unless otherwise required by state or federal laws or healthcare mandates (e.g. loss of coverage under Medicaid or CHIP allows up to 60 days to obtain coverage) or extended to 31 days by the Plan Administrator. *To make an election change, contact your Plan Administrator listed in Article 3.*

3.5 Plan Benefits and Cost Sharing Provisions

Participant Contributions

Participant premium contributions for coverage are fixed, and the employer bears the risk of premium and/or administrative cost above that amount.

Participant premium contributions for Medical, Dental, Vision, Health Flexible Spending Account (FSA) and Dependent Care FSA benefit(s) are paid pre-tax. Participant premium contributions for Life/AD&D benefit(s) are paid post-tax.

If the Plan has cost sharing with a Cafeteria Plan, employee contributions for qualifying benefits will be paid through a pre-tax payroll deduction starting the first pay period following enrollment, unless they are benefits that are not eligible for pre-tax deduction such as life or disability insurance or the Employee requests post-tax deductions.

Contributions will be paid at various times for different classes of employees. Contributions for Office/Shop/Driver employees will be paid weekly. Contributions for Driver employees will be paid bi-weekly.

Actual contribution rates will be published each year during the open enrollment period. See summary of coverage for additional deductible, coinsurance, copayments, services, and coverage, and enrollment documents for applicable rates and contribution levels.

Company Contribution Levels

The Company will make its contributions in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by the eligible Employee's contributions. The Company will pay its contribution and the eligible Employee's contributions to the Insurer or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to or on behalf of the Participants from the Company's general assets. The eligible Employee's contributions toward the cost of a particular benefit will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit.

Insurance premiums for Employees and their eligible family members are paid in part by the Company out of its general assets and in part by employees' pre-tax payroll deductions, where applicable. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the component benefit programs, as applicable. Contributions for the self-insured component benefit programs are also made in part or in whole by the Company and/or in part or in whole by employees' pre-tax or post tax payroll deductions. For those benefits offered through a trust, Employee withholdings and/or Employer contributions are remitted to the respective trust, and the trust, subject to the trust agreement, shall forward the cost of the premiums to the Insurance carrier.

For those benefits offered through a trust (i.e., Medical benefits), Employee withholdings and/or Employer contributions are remitted to the respective trust, and the trust, subject to the trust agreement, shall forward the cost of the premiums to the Insurance Carrier (i.e., Blue Cross Blue Shield of North Dakota).

Ordering of Participant and Company Contributions

This section applies unless the plan sponsor has adopted specific written procedures or a document that specifies a different ordering for plan contributions or for plan receipts to plan contributions.

- All participant contributions will be applied first to cover premiums or benefit costs, and then Employer contributions will be applied to cover any remaining premiums or benefit costs plus the cost of other plan expenses, including stop-loss premiums if applicable.

- If any component of the Plan is self-insured and the Employer has purchased a stop-loss policy (and the employer, not the Plan, is the policyholder), any stop-loss proceeds will be treated as fully allocable to employer contributions. This applies even if stop-loss premiums were included in calculating total plan costs. Participant contributions will not be used to pay stop-loss premiums. (If the Employer is the policyholder, the employer is entitled to reimbursement for amounts it pays above a specified threshold level for allowed claims during the relevant period. The stop-loss policy is not a plan asset and does not reimburse participants for claims costs.)

- In the event a medical loss ratio (MLR) rebate or other type of rebate is paid to the Plan, the portion of the rebate that does not exceed the Employer's total amount of prior contributions during the relevant period will be attributable to Employer contributions, not to participant contributions.

Flexible Spending Accounts

If you have healthcare costs not covered by medical, dental, or vision coverage, or work related dependent care costs for child(ren) under 13 years of age (or disabled adult family member), you may be able to pay for these expenses through a Flexible Spending Account offered by the Employer.

Health FSA

If you have healthcare expenses not covered by the medical plan(s) offered, you may be able to pay for expenses using pre-tax dollars through the Health Flexible Spending Account (Health FSA). This is a voluntary only benefit plan with employees estimating anticipated expenses for qualifying uncovered medical or dental costs, then authorizing payroll deductions for these amounts. The Health FSA is funded by employee contributions. The Employer does not make a contribution of any dollar amount toward the Health FSA on behalf of the employee. Refer to component plan documents for more information.

The Health FSA allows a limited carryover of your account balance(s) from Plan Year to Plan Year in accordance with the conditions and restrictions set forth by the IRS. The maximum amount allowed by the IRS for carryover under the Health FSA may vary from Plan Year to Plan Year. Contact your Plan Administrator for more information about the maximum amount allowed

for carryover for the applicable Plan Year. The actual balance of your account that may be carried over will be determined upon expiration of the Claims Run Out Period described in section 3.10. Any amounts remaining in your account attributable to a particular Plan Year after the carryover shall be forfeited.

Dependent Care FSA

You may also be able to pay for dependent care expenses, such as child day care, using pre-tax dollars through the Dependent Care Flexible Spending Account (Dependent Care FSA). This is a voluntary only benefit plan with employees estimating anticipated expenses for qualifying dependent care costs, then authorizing payroll deductions for these amounts. The Employer does not make a contribution of any dollar amount towards the Dependent Care FSA on behalf of the employee. Refer to component plan documents for more information.

Health Reimbursement Arrangement (HRA)

A Health Reimbursement Arrangement (HRA) is an arrangement funded entirely by the Employer and without taxation to you individually that allows possible reimbursement for eligible medical expenses incurred by participants as well as their spouse and/or dependent(s). You must be enrolled in the Medical Plan benefit to be eligible to participate in the HRA. The Employer may reimburse 80% of charges a participant has incurred for Eligible Medical Care Expenses, up to a maximum amount of $3,000. For details regarding how the HRA works, who is eligible to participate, how to file a claim, what an eligible claim is, payment of claim, when participation ends, continuation options and coordination of benefits between HRA and other health plan options, refer to your HRA Plan Document or speak with the plan administrator.

3.6 Component Benefit Plan Documents

All documents relating to the Holland Enterprises, Inc. Health & Welfare Benefits Plan, including the Evidence/Certificate of Coverage for each plan, Listing of Network Providers, Contribution Rates, General COBRA Notice, Medicare Creditable Coverage Notice, and any other relevant Plan Documents or Notices, are available to Employees and their dependents by contacting the Plan Administrator. Plan participants may receive a paper copy of any of the above documents free of charge by contacting the Plan Administrator.

Please refer to the component plan documents for each plan's specific details, including a description of benefits, cost-sharing provisions, requirements for use of network providers, and circumstances by which benefits may be denied.

3.7 Possible Limits on or Loss of Benefits

Summary of Benefits and Coverage

See component plan documents and Summary of Benefits and Coverage (SBC) for details regarding deductibles, co-pays, coverage, claims procedures, resources and provider company information.

Coordination of Benefits

For Participants and Dependents who do not maintain coverage under a health and welfare plan sponsored by another unrelated employer's health and welfare plan, the Plan will be the primary payer for all eligible claims and benefits as defined in the underlying component benefit program documents. If participants or dependents are covered by another medical or insurance plan, the two plans will coordinate together eliminating duplication of payments as explained in the component plan documents. The insurer, Third-Party Administrator or the fiduciary has primary responsibility to coordinate benefits for eligible expenses for other employer plans, government plans, Medicare or other coverage such as motor vehicle insurance.

Subrogation of Benefits

The Insurer or third-party administrator shall undertake reasonable steps to identify which Plan has a subrogation interest and shall manage subrogation cases on behalf of the Plan. You are required to cooperate with the Insurer or Third-Party Administrator to facilitate enforcement of its rights and interests. Participants must fully cooperate and do their part to ensure the Plan's right of recovery and subrogation are secured. If the Participant fails or refuses to honor the Plan's recovery and subrogation rights, the Plan may recover any cost to enforce its rights. This includes, but is not limited to, attorney fees, litigation court cost and other expenses as covered in the underlying component benefit program documents.

Rescission

Benefits for you and/or your enrolled dependent(s) will be terminated retroactively (this is known as *"rescission"*) if the Carrier or Plan Administrator determines that you obtained benefits under the Plan as a result of fraud or intentional misrepresentation of a material fact. You will be given 30 days prior written notice, and coverage will be terminated back to the date of the fraud or intentional misrepresentation. You

will be required to reimburse the Plan for any benefits you or your eligible dependent(s) received since the date of the fraud or material misrepresentation, and such amount will be offset against the premiums you paid before they are refunded to you, to the extent allowed by applicable law.

Denial or Loss of Benefits

A Participant's benefits under the Plan will cease when the eligible Employee's participation in the Plan terminates. A Participant's benefits will also cease on termination of the Plan. Other circumstances can result in termination, reduction or denial of benefits. Refer to the component benefit program documents for details regarding when a plan may terminate.

3.8 Termination of Benefits

Benefits under any Component Benefit Program will terminate for all participants if that Component Benefit Program is terminated and will terminate for a particular participant if his or her participation is ended due to loss of eligibility or termination of employment or other reason.

Dental and Vision benefits terminate the last day of the month in which eligibility ends. Life/AD&D benefits terminate the last day of employment. Medical benefits terminate on the 15th or the last day of the month following loss of eligibility date. Health Reimbursement Arrangement (HRA) benefits terminate on the last day of coverage under the Medical Plan associated with the HRA.

Plans may or may not have conversion options (check with Plan Administrator). See continuation options available for such benefits as medical, dental, vision and Health Flexible Spending Accounts, if applicable, under COBRA (Consolidated Omnibus Budget Reconciliation Act) as explained below. Check with the Plan Administrator for possible conversion options or questions on possible continuation rights. See each component benefit program documents for termination provisions.

An eligible Employee's participation and the participation of his or her eligible Dependents in the Plan will terminate on the date specified in the component benefit program documents. Other circumstances can result in the termination of benefits as described in the component benefit program documents.

Participation in the Plan may be terminated due to disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, etc. Refer to the corresponding component benefit program documents for detailed information. Holland Enterprises, Inc. reserves the right to change, cancel, or alter all or any portion of the Employee Welfare Benefit Plan as it deems necessary.

The Company has the right to terminate the Plan in its entirety, or any portion thereof at any time. In the event that the Plan is terminated, the Plan may provide a written notice of 60 days in advance, when possible.

An officer, as designated by the Company, may sign insurance contracts for this Plan on behalf of the Company, including amendments to those contracts, and 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.

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, previously sent documents or available through the Plan Administrator, provide additional information.

3.9 Plan Amendment and Termination

Amendment of the Plan

The Employer reserves the right to amend, modify, or discontinue the Plan in any respect, including but not limited to, implementing a change in the amount or percentage of premiums or cost that must be paid by the Participant. No Participant shall have any vested right to any benefits under the Plan, subject to any duty to bargain that may exist. The Company shall have the right to amend the Plan at any time and to any extent deemed necessary or advisable; provided, however, that no amendments shall:

1. Have the effect of discriminatorily depriving, on a retroactive basis, any eligible Employee, dependent or beneficiary of any beneficial interest that has become payable prior to the date such amendment is effective; or

2. Have the result of diverting the assets of the Plan to any purpose other than those set forth in this Plan.

An officer, as designated by the Company, may sign insurance contracts for this Plan on behalf of the Company, including amendments to those contracts, and 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.

Termination of the Plan

In the event that the Plan is terminated, a written notice may be given to participants 60 days in advance, when possible. If the Plan is amended, the employer will promptly provide notice to participants as required under applicable law and shall execute any instruments necessary in connection therewith.

The Company shall promptly notify the Plan Administrator and all interested parties of any amendment adopted pursuant to this Section.

3.10 Claims Procedures

Overview of Claims Procedures

Details regarding the Plan's claim procedures are furnished automatically, without charge, as a separate document, copies of which are included with this document, were previously provided, or can be obtained from the Plan Administrator. These will comply with applicable ERISA requirements.

Generally, to obtain benefits from the Insurer or Third Party Administrator (TPA) of a provided component benefit program, you must follow the claims procedures under the applicable component benefit program documents, which may require you to complete, sign, and submit a written claim on the Insurer's or Third Party Administrator's form. In that case, the form is available from the Plan Administrator.

Summary of the ERISA claims and appeals process, for any type of ERISA benefits:

1. Claim is filed – by the plan participant or his/her authorized representative.
2. Claim is either paid in full or denied in whole or in part – by the Insurer or Third Party Administrator (TPA). If the claim is denied in whole or in part, this is called an "Adverse Benefit Determination."
3. Appeal of Adverse Benefit Determination – by the plan participant or his/her authorized representative.
4. Final decision on the appeal – by the Insurer or Third Party Administrator (TPA).

If your appeal is denied, or if the Insurer or Third Party Administrator (TPA) does not comply with the ERISA timeframes specified below, you can file a civil action (lawsuit) in Federal court, under ERISA section 502(1).

Flexible Spending Accounts

You may submit claims for reimbursement of eligible expenses incurred during the plan year for a period of time that begins on the first day following the close of the Plan Year or, if applicable, the Grace Period. This period of

time is referred to as a Run Out Period. The Flexible Spending Accounts have a Plan Year Run Out Period of 60 days after the plan year ends for you to submit claims for reimbursement. All claims must be incurred prior to the end of the plan year. The Flexible Spending Accounts have a Terminated Employee Run Out Period of 60 days after the last date of employment. All expenses must be incurred prior to the employee's last day of employment.

The grace period is the period of time beginning the day after the end of each Plan Year. Claims incurred during the grace period will be considered to have been incurred during both the preceding Plan Year and the current Plan Year, and will be first allocated to and reimbursed from your account for the preceding Plan year until such account is exhausted. Thereafter, any such claims will be allocated to and reimbursed from your account for the current Plan Year. The Dependent Care FSA has a grace period of 2.5 months after the last day of each plan year.

Standard Claims Procedures for Medical Benefit

Fully-Insured Medical Benefits

For purposes of determining the amount of, and entitlement to benefits under a component medical program whose benefits are paid under an insurance policy, the Insurance Company is the Named Fiduciary and shall have the full power to make factual determinations and to interpret and apply the terms of the policy as they relate to the benefits provided through the insured arrangement, unless the Plan Administrator has explicitly and in writing retained the right to make a final determination. The Insurance Company is also the Claims Administrator for purposes of claims determinations.

Self-Funded Medical Benefits

For purposes of determining the amount of, and entitlement to benefits under a component medical program whose benefits are paid from the Company's general assets, the Plan Administrator shall have the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement, except to the extent the Plan Administrator has appropriately delegated such responsibility to a Claims Administrator. This is specified in the appropriate Component Benefit Program documents.

To obtain benefits from a self-funded arrangement, the Participant may be asked to complete, execute and timely submit to the Claims Administrator or Plan Administrator a written claim on the form available from either the Claims Administrator or Plan Administrator.

The Claims Administrator or Plan Administrator will decide the claim in accordance with reasonable claims procedures, as required by ERISA. ERISA imposes specific maximum timeframes for different types of medical claims (e.g., pre-authorization, emergency, post-treatment), and these are specified in the applicable documents for Component medical benefits. The Plan Administrator or the Claims

Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide his or her claim. If the Claims Administrator or Plan Administrator denies the Participant's claim, in whole or in part, it will send written notification setting forth the reason(s) for the denial.

If a Participant's claim is denied, he or she may appeal to the Named Fiduciary, for a review of the denied claim. The Named Fiduciary will decide the appeal in accordance with reasonable claims procedures, as required by ERISA. If the Participant doesn't appeal on time, he or she will lose his or her right to file suit in a state or federal court, as he or she has not exhausted the internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court). The insurance documents or other governing documents for the Component Benefits contain more information about how to file a claim and details regarding the claims procedures applicable to the claim.

After a Participant's appeal for Medical Benefits has been denied by Named Fiduciary, he or she shall be eligible to file a request for review under the external review procedure as provided under Treasury Regulations Section 54.9815-2719T(d)(1)(i); DOL Regulations Section 2590.715-2719(d)(1)(i) and HHS Regulations Section 147.136(d)(1)(i), if applicable.

Claims Procedure for Benefits Based on a Determination of Disability

ERISA claims procedures apply specifically to claims made under the Plan for benefits based on a determination of disability. However, if the Plan Administrator has delegated and named an insurer or third party administrator as the claims fiduciary, then such entity shall have full discretion and authority to determine eligibility for such benefits, and the insurer’s or third party administrator’s claims procedures shall apply as long as such other claims procedures comply with current Department of Labor Regulations. For additional information, please contact the disability insurer.

Additionally, if a disability determination is made outside the plan for reasons other than determining eligibility for plan benefits, the new ERISA disability claims procedures shall not apply. Examples of when the ERISA disability claims provisions do not apply are where the disability determination is based solely on whether the claimant is entitled to disability benefits under either the Social Security Act or the employer's long term disability plan.

Below is a short summary of the disability claims procedures effective for claims if: a) the Plan Administrator makes the disability determination, or b) the Plan Administrator has designated a separate claims fiduciary but that entity’s claims procedures are not compliant with applicable DOL regulations.

1. If the claims administrator denies your claim, it must notify you of its decision within 45 days of receipt of your completed claim, except that it may extend the time by not more than two additional 30-day periods if it first notifies you in writing and if certain other requirements are met.

2. Any adverse benefits determination will include the specific information specified in the DOL final regulations.

3. You have 180 days to appeal an adverse benefit determination. You may request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. You may submit information and opinions from experts who were not involved in the initial claim.

4. Within 45 days after the Claims Administrator receives your appeal request, it will notify you of its decision on your appeal, except that this period may be extended for an additional 45-day period if special circumstances (such as the need to hold a hearing) require an extension of time. In such case, you will be notified in writing of the need for the extension. The individual reviewing your appeal shall not be the same individual who made the initial benefit decision, shall give no deference to the initial benefit decision and shall not be a subordinate of the initial decision maker. If your appeal is granted, the decision will contain information sufficient to reasonably inform you of that decision. If the reviewing fiduciary anticipates denying your appeal, whether in whole or in part, the fiduciary must provide you certain information (free of charge) as soon as possible and sufficiently in advance of the date the final decision must be rendered, to provide you a reasonable opportunity to review the information and submit a response. If your appeal is denied, you will be sent written notice which includes the information specified in the final regulations.

3.11 Affordable Care Act Compliance

The Plan complies with all applicable Patient Protection and Affordable Care Act (PPACA) provisions, as detailed in component plan documents. PPACA applies only to health benefits. It does not apply to other benefits under the Plan, such as dental, vision, life, disability, “excepted” benefits (as defined by law and regulations) or other categories of benefits.

PPACA compliance includes, but is not limited to:

- Coverage of dependents up to age 26
- No annual or lifetime dollar limits on "Essential Health Benefits" as defined in PPACA and regulations
- No pre-existing conditions exclusions
- Prohibition on rescissions
- Patient protections – coverage and payment for emergency services, primary care provider designation, designation of pediatric physician as primary care provider, no prior authorization for access to obstetrical or gynecological care.
- Preventive care – specified preventive care services are covered on a first-dollar basis, not subject to co-payments, co-insurance, deductibles or other cost-sharing requirements.
- Nondiscrimination testing – this Plan is intended to comply with current nondiscrimination rules.

3.12 ERISA Notices

With respect to offered group Health Plans, the Plan will provide benefits in accordance with the requirements of all applicable laws, such as (but not limited to): COBRA, HIPAA, HITECH, MHPA, NMHPA, USERRA, GINA, MHPAEA, WHCRA, HCERA and PPACA.

Notice of Rights Under the Newborns & Mothers Health Protection Act ("NMHPA")

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

Notice of Women's Health & Cancer Rights Act ("WHCRA")

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the applicable component benefit. Refer to the insurance certificate or benefit booklet for information on the deductibles and coinsurance that apply.

If you would like more information on WHCRA benefits, contact the plan administrator.

Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event. If you are declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the Plan Administrator.

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage) provided that you meet participation requirements. However, you must request enrollment within 30 days (or any

longer period that may apply under the plan) after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days (or any longer period that may apply under the plan) after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Plan Administrator.

HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information. **As Required by Law,** we will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

Family and Medical Leave Act ("FMLA")

To the extent the Plan is subject to The Family and Medical Leave Act of 1993 (FMLA), the Plan Administrator will permit a Participant taking unpaid leave under the FMLA to continue group health benefits under such applicable law. Non-medical benefits will continue according to the established Company policy. Participants continuing participation pursuant to the foregoing will pay for such coverage (on a pre-tax or after-tax basis) under a method as determined by the Plan Administrator satisfying applicable regulations. If the Participant's coverage under the Plan terminates while the Participant is on FMLA leave, the Participant is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. Upon reinstatement into the Plan upon return from FMLA leave, the Participant has the right to resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments, or resume coverage at a level that is reduced by the amount of unpaid premiums and resume premium payments at the level in effect before the FMLA leave.

Mental Health Parity and Addiction Equity Act ("MHPAEA")

The MHPAEA applies to class health benefits provided under this Plan that provide both medical and surgical benefits as well as mental health or substance use disorder benefits. The MHPAEA requires that:

- The financial requirements that apply to mental health or substance use disorder benefits cannot be more restrictive than the predominant financial requirements that apply to substantially all medical and surgical benefits under the Plan, and no separate cost-sharing requirements can be applied only to mental health or substance use disorder benefits.

- The treatment limitations that apply to mental health or substance use disorder benefits cannot be more restrictive than the predominant treatment limitations that apply to substantially all medical and surgical benefits under the Plan, and no separate treatment limitations can be applied only to mental health or substance use disorder benefits.

The component plan determines what mental health condition and/or substance use disorder coverage is provided. You may request information from your employer-sponsored health plan or your group or individual market insurer regarding treatment limitations that may affect your access to mental health or substance use disorder benefits, including nonquantitative treatment limitation (NQTL) analysis. To request this information, complete the Department of Labor form template found at **https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template-draft.pdf** and return the completed form to your Plan Administrator.

Uniformed Services Employment and Reemployment Rights Act ("USERRA")

The Uniformed Services Employment and Reemployment Rights Act (USERRA), protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free From Discrimination and Retaliation

If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you: initial employment; reemployment; retention in employment; promotion; or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

If you leave your job to perform military duty of more than 30 days, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries. For military service of less than 31 days, you are entitled to your existing employer-based health coverage for you and your dependents as if you were employed continuously and will continue to pay your regular premium.

Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint,

or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **https://webapps.dol.gov/elaws/vets/userra/**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

Genetic Information Nondiscrimination Act of 2008 ("GINA")

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits the Plan from discriminating against individuals on the basis of genetic information in providing any of the benefits under provided benefit plans.
GINA generally:

- Prohibits the Plan from adjusting premium or contribution amounts for a group on the basis of genetic information;

- Prohibits the Plan from requesting or mandating that an individual or family member of an individual undergo a genetic test, provided that such prohibition does not limit the authority of a health care professional to request an individual to undergo a genetic test, or preclude a group health plan from obtaining or using the results of a genetic test in making a determination regarding payment;

- Allows the Plan to request, but not mandate, that a participant or beneficiary undergo a genetic test for research purposes if the Plan does not use the information for underwriting purposes and meets certain disclosure requirements; and

- Prohibits the Plan from requesting, requiring, or purchasing genetic information for underwriting purposes, or with respect to any individual in advance of or in connection with such individual's enrollment.

Michelle's Law

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the Plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or the date coverage would otherwise terminate under the Plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the Plan, of a participant or beneficiary; and
- Have been enrolled in the Plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the Plan.

If you believe your child is eligible for this continued eligibility, you must provide to the Plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact the Plan Administrator.

Discrimination is Against the Law

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic

formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Plan Administrator.

If your Company has fifteen (15) or more Employees and you believe that The Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, refer to the Plan Administrator for Grievance Procedures or if you need help filing a grievance. A grievance can be filed in person, by mail, fax, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

Centralized Case Management Operations
U.S. Department of Health and Human Services 200
Independence Avenue, SW
Room 509F, HHH
Building Washington,
D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at:
https://www.hhs.gov/sites/default/files/ocr-60-day-frn-cr-crf-complaint-forms-508r-11302022.pdf.

Participant's Responsibilities

Each Participant shall be responsible for providing the Plan Administrator, Claims Administrator, if applicable, and the Company and, if required by an Insurance Company or Third Party Administrator, with respect to a fully-insured benefit, the Insurance Company with his or her current address. If required by the Insurance Company, with respect to a fully-insured benefit, each Employee who is a Participant shall be responsible for providing the Insurance Company with the address of each of his or her covered eligible

dependents. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The Insurance Companies, the Plan Administrator and the Company shall have no obligation or duty to locate a Participant.

Documenting Eligibility for Enrollment and Benefits

Any person claiming benefits under the Plan shall furnish the Plan Administrator or, with respect to a fully-insured benefit, the Insurance Company or Third Party Administrator with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan. Refer to details in the component benefit program documents.

The Plan Administrator, Claims Administrator, if applicable, (and, with respect to a fully-insured benefit, the Insurance Company) shall have the right and opportunity to have a Participant examined when benefits are claimed, and when and as often as it may be required during the pendency of any claim under the Plan.

Your Rights and Protections Against Surprise Medical Bills

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

What is “balance billing” (sometimes called “surprise billing”)?

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

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

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

Effective January 1, 2022, you are protected from balance billing for:

Emergency services

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

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

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

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

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

<u>When balance billing isn't allowed, you also have the following protections:</u>

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

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an

in-network provider or facility and show that amount in your explanation of benefits.

- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact HHS, in coordination with the Department of the Treasury, Department of Labor and the Office of Personnel Management at 1-800-985-3059.

There are currently no protections against surprise medical bills under state law of North Dakota.

3.13 HIPAA Privacy and Security Compliance

Application

The Privacy and Security Rules in the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) apply only to those Component Benefit Programs that constitute group health plans that are subject to HIPAA, and that are self-funded or for which the plan sponsor uses or discloses "protected health information" (PHI). Such group health plans are "Covered Programs" under HIPAA.

Privacy and Security Policy

The Covered Programs will adopt HIPAA privacy and security policies, as appropriate.

Business Associate Agreement

The Covered Programs will enter into a business associate agreement with any persons or entities as may be required by applicable law, as determined by the Plan Administrator.

Notice of Privacy Practices

The Covered Programs will provide each Participant with a notice of privacy practices to the extent required by applicable law.

Disclosure to the Company

In General

This Subsection permits the Covered Programs to disclose PHI to the Company to the extent that such PHI is necessary for the Company to carry out its administrative functions related to the Covered Programs.

If part of their job responsibilities include administration or management of the group health plan, there may be times that the following departments have access to an employee's PHI: Accounting, IT, Legal, HR, Benefits. Examples of how their job responsibilities may require access to PHI or ePHI include (but are not limited to): payment of claims; review of amounts paid for medical services; legal review of claims or appeals or benefits issues; or access to ePHI that is at rest on (or in transit using) the employer's server, network, Intranet or Internet.

If you have any questions as to the person/persons that have access to this information, please see your plan administrator.

Permitted Disclosure

a. Permitted Disclosure of Enrollment/Disenrollment Information

The Covered Programs may disclose to the Company information on whether an individual is participating in the Covered Programs. Enrollment and disenrollment functions performed by the Company are performed on behalf of Participant and beneficiaries of the Covered Programs and are not plan administration functions. Enrollment and disenrollment information held by the Company is held in its capacity as an employer and is not PHI.

b. Permitted Uses and Disclosure of Summary Health Information (SHI)

The Covered Programs may disclose Summary Health Information, as defined in the HIPAA privacy rules, to the Company, provided that the Company requests the Summary Health Information for the purpose of (i) obtaining premium bids from health plans for providing health insurance coverage under the Covered Programs; or (ii) modifying, amending, or terminating the Covered Programs.

c. Information Disclosed Pursuant to a Signed Authorization

Information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR 164.508 is not subject to any restrictions, except as specified on the signed authorization.

d. Permitted and Required Uses and Disclosure of Protected Health Information (PHI) for Plan Administration Purposes

If the component health plans have not already been amended to include this information, this Wrap document amends them to incorporate the following provisions, which allow the Covered Programs to disclose PHI to the Plan Sponsor for "plan administration

purposes" as defined in HIPAA regulations. This includes quality assurance, claims processing, auditing, and monitoring. The Plan Sponsor shall only use such PHI for purposes of plan administration and not for any employment-related actions or decisions. This section also serves as Certification from the Plan Sponsor that its component Health Programs have been amended to include the following limitations/restrictions:

- *Use and Further Disclosure:* The Company will not use or further disclose PHI other than as permitted or required by the Plan document or as required by all applicable law, including but not limited to the HIPAA privacy rules. When using or disclosing PHI or when requesting PHI from the Covered Programs, the Company will make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.

- *Agents and Subcontractors:* The Company will require any agents, including subcontractors, to whom it provides PHI received from the Covered Programs to sign Business Associate Agreements and to agree to the same restrictions and conditions that apply to the Employer, Company or Plan Sponsor with respect to such information.

  Questions regarding use of PHI should be directed to the Insurer or Third Party Administrator in question. The Insurer or Third Party Administrator will advise a Plan Participant who wants to exercise any of his/her rights concerning PHI, of the procedures to be followed.

- *Employment-Related Actions:* Except as permitted by the HIPAA privacy rules and other applicable federal and state privacy laws, the Company will not use PHI for employment-related actions and decisions, or in connection with any other employee benefit plan of the Company.

- *Reporting of Improper Use or Disclosure:* In accordance with (16 CFR Part 318), Health Breach Notification Rule, where applicable, agrees to notify both the participants, the Federal Trade Commission and Covered Programs of any use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, or which the Plan Sponsor or any Business Associate of the Plan Sponsor becomes aware.

- *Adequate Separation. The Company will ensure that adequate protection of PHI and separation between the Covered Programs and the Company (i.e., a "firewall") is established and maintained.*

- *Comply with Individual's Privacy Rights:* The Company will make available PHI to comply with an individual's right to access PHI, or to amend PHI (and the Company will make any appropriate amendments); the Company will make available the information required to provide an accounting of disclosures when requested by an individual.

- *Information to HHS:* The Company will make its internal practices, books, and records relating to the use and disclosure of PHI received from the Health Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Plan with HIPAA's privacy requirements.

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

3.14 COBRA Notice

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the company plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. Coverage in the Health Reimbursement Arrangement (HRA) may also be continued if the employee elects to continue Medical coverage. For more information about your rights and obligations

under the Plan and under federal law, you should review this Summary Plan Description or contact the Plan Administrator.

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.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 (or 31) days of the event.

If applicable, your participation in the Health Flexible Spending Account can also continue on an after-tax basis through the remainder of the Plan Year in which you qualify for COBRA. The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all qualified beneficiaries.

If you make contributions to the Health Flexible Spending Account for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the Plan Year.

You may be offered to continue your coverage under the Health Flexible Spending Account if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the qualified beneficiary for the Plan Year (e.g., $2,550 of coverage); (2) the total reimbursable claims

submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is overspent. You may not re-enroll in the Health Flexible Spending Account during any annual enrollment for any Plan Year that follows your qualifying event.

Supporting documentation like a divorce decree, death certificate, proof of other insurance may be required as proof of a qualifying event.

This general notice does not fully describe COBRA or the plan. More complete information is available from the plan administrator and in the summary plan document.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the 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 lose your coverage under the 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 benefits (under 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 lose coverage under the 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 benefits (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.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator 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 the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee must notify the Plan Administrator of the qualifying event.

For all 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), employees must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying

event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. 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 the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Documentation from the Social Security administration certifying a disability will be required.

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **https://www.healthcare.gov/**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

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:

1. The month after your employment ends; or
2. 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.**

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the plan administrator indicated above or in the summary plan description. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about 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.

3.15 Statement of ERISA Rights

The Employee Retirement Income Security Act of 1974 (ERISA) provides that all Plan participants shall be entitled to the rights discussed below. Note that Cafeteria Plans, including any Dependent Care Flexible Spending Arrangement offered under the Cafeteria Plan, are not subject to ERISA.

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and if the group has 100 or more participants, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US Department of Labor. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series, if 100 or more participants) and updated Summary Plan Description. Receive a summary of the Plan's annual financial report.

Continue Group Health Plan Coverage

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. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your Plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, free of charge, from your Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you my be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Foreign Language

This document contains a summary in English of your plan rights and benefits under the group health plan. If you have difficulty understanding any part of this document, contact the Plan Administrator indicated above.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interests of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. 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 domestic relations order or 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 US Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining

documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit Security Administration (EBSA) US Department of Labor, listed in your telephone directory or (866) 444-3272. You may also obtain EBSA contact information at: **https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa**. You may further obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

ARTICLE 4. General Provisions

4.1 No Right to Employment

Nothing contained in this Plan will be construed as a contract of employment between the Company and you, or as a right of any Employee to continue in the employment of the Company, or as a limitation of the right of the Company to discharge any of its employees, with or without cause "at will".

4.2 Governing Law

The Plan will be construed in accordance with and governed by the laws of the state or commonwealth of organization of the Plan Sponsor (i.e., North Dakota) to the extent not preempted by federal law. The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

4.3 Tax Effect – Notice about Pre-Tax Payments and Possible Effect on Future Social Security Benefits

Where possible, the Company provides benefits under the Plan on a pre-tax basis in accordance with federal tax law. Some benefits may be obtained on an after tax basis. The Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

If this Plan allows you to pay for benefits on a pre-tax basis, you will not pay Social Security taxes on the pre-tax dollars you use to pay for coverage. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these contributions. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the Plan normally will be greater than any eventual reduction in Social Security benefits.

4.4 Refund of Premium Contributions

For fully-insured component benefit programs, the Plan will comply with Department of Labor (DOL) guidance regarding refunds (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates (MLR) of insurance premiums). To the extent that the Company receives rebates determined to be plan assets to the extent amounts are attributable to insurance premiums paid by Participants, the rebates will (a) be distributed within 90 days of receipt to the Participants covered by the policy to which the rebate relates under a reasonable, fair, and objective allocation method or (b) if distributing the rebates would not be cost-effective because the amounts are small or would give rise to tax consequences to the Participants, the rebates may be used to pay future Participant premiums or for benefit enhancements which benefit the Participants covered by the policy to which the rebate relates. Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the cost to the Plan and the competing interest of participants. Any rebates attributable to insurance premiums paid by the Company shall be retained by the Company.

4.5 Facility of Payment

When, in the Company or its designated representative's opinion, any Participant under the Plan is under a legal disability or is incapacitated in any way so as to be unable to manage his financial affairs, the Company or its representative may direct that payments be made to such Participant's legal representative or withhold payment pending an adjudication of the Participant's legal capacity and the appointment of a legal representative. The Company or its designated representative may also direct that payment be applied for the benefit of the Participant any way the Company considers advisable. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan, the Company or the Employer to the extent of such payment. Any payment requirement shall include payments to a Participant’s beneficiary in the case of death benefits paid under the Plan.

4.6 Data

Participants who may receive benefits under the Plan must furnish the Company, or its designated representatives such documents, evidence, information, releases or authorizations, as it considers necessary or desirable for the purpose of administering the Plan, or to protect the Company. It shall be a condition of the Plan that each such person must furnish such information promptly and sign such documents as the Company may require before any benefits become payable under the Plan.

4.7 Electronic Communications

Whenever an Employee, Participant, Spouse, other Dependent or beneficiary is required to provide information or perform a written process, the Plan Administrator may, in its discretion, permit or require that electronic means be used. In addition, meetings with the Plan Administrator may be held in person or through electronic or telephonic means or a combination thereof and written actions of the Plan Administrator may be taken using electronic or conventional means. In the use of electronic communication, the Plan Administrator shall follow all guidelines published by the Department of Labor and the Internal Revenue Service.

4.8 Non-Assignability and Spendthrift Clause

To the extent permitted by law, the benefits or payments under the Plan will not be subject to alienation, sale, assignment, pledge, attachment, garnishment, execution, encumbrance or other transfer, nor will they be subject to any claim by any creditor of any Participant under the Plan other than a physician or treatment facility so authorized by the Participant or to legal process by an creditor of any Participant (except in the case of death or obligations owed to the Company). Any attempt to circumvent these provisions shall be considered null and void.

4.9 Severability of Provisions

If any provision of the Plan is held invalid or unenforceable, such invalidity or unenforceability will not affect any other provisions hereof, and the Plan will be construed and enforced as if such provisions had not been included.

4.10 Effect of Mistakes

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator will, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Company from Compensation paid by the Company.

4.11 Compliance with State and Federal Mandates

With respect to all Component Programs, the Plan will comply, to the extent applicable, with the requirements of all applicable laws, including (but not limited to): USERRA, COBRA, FMLA, HIPAA, WHCRA, HITECH, NMHPA, MHPA, MHPAEA, GINA, Michelle's Law, and PPACA.

ARTICLE 5. Component Benefit Programs – Provider Companies

Medical Insurance

- **Plan Name:** Medical Insurance Plan

  Name of Provider: Blue Cross Blue Shield of North Dakota

  Plan Funding: Self Insured

  Administration: Shared between Holland Enterprises, Inc. and Blue Cross Blue Shield of North Dakota via the Associated Trust (Fargo-Moorhead Home Builders Health Plan & Trust)
  Provider Address: 4510 13th Ave. S. , Fargo, ND, 58121

  Provider Phone: 844-363-8457

  Provider URL : www.bcbsnd.com

Dental Insurance

- **Plan Name:** Dental Insurance Plan

  Name of Provider: Standard Insurance Company

  Plan Funding: Fully Insured

  Administration: Shared between Holland Enterprises, Inc. and Standard Insurance Company

  Provider Address: 900 SW Fifth Avenue, Portland, OR, 97204-1282

  Provider Phone: 503-321-7000

  Provider URL : https://www.standard.com/

Vision Insurance

- **Plan Name:** Vision Insurance Plan

Name of Provider: Avesis

Plan Funding: Fully Insured

Administration: Shared between Holland Enterprises, Inc. and Avesis

Provider Phone: 833-282-2441

Provider URL : **www.avesis.com**

Life/AD&D Insurance

- **Plan Name:** Voluntary Life/AD&D Insurance Plan

  Name of Provider: Standard Insurance Company

  Plan Funding: Fully Insured

  Administration: Shared between Holland Enterprises, Inc. and Standard Insurance Company

  Provider Address: 900 SW Fifth Avenue, Portland, OR, 97204-1282

  Provider Phone: 503-321-7000

  Provider URL : **https://www.standard.com/**

Health Reimbursement Arrangement (HRA)

- **Plan Name:** Health Reimbursement Arrangement

  Name of Provider: ConnectYourCare / Optum Financial

  Administration: Shared between Holland Enterprises, Inc. and ConnectYourCare / Optum Financial

  Provider Phone: 877-292-4040

  Provider URL : **https://www.connectyourcare.com/**

Flexible Spending Account (FSA)

- **Plan Name:** Health FSA

  Name of Provider: ConnectYourCare / Optum Financial

  Administration: Shared between Holland Enterprises, Inc. and ConnectYourCare / Optum Financial

Dependent Care Flexible Spending Account (FSA)

- **Plan Name:** Dependent Care FSA

  Name of Provider: ConnectYourCare / Optum Financial

  Administration: Shared between Holland Enterprises, Inc. and ConnectYourCare / Optum Financial

Note: Dependent Care Flexible Spending Accounts (FSAs) are not subject to ERISA and are included in this document for informational purposes only.

ARTICLE 6. Pandemic Related Plan Provisions

Extension of Certain Timeframes due to the COVID-19 Emergency

Effective Date: February 26, 2021

The US Department of Labor announced that, due to the ongoing national emergency caused by the COVID-19 outbreak, certain timeframes required under ERISA and the IRS have been extended. These dates were further clarified by IRS Guidance 2021-58 in October 2021. Specifically, applicable deadlines that fall within the Outbreak Period are extended until the earlier of: (i) the one-year anniversary of the otherwise applicable deadline, or (ii) sixty days after the end of the Outbreak Period. This applies to deadlines applicable to individuals participating in the plan, as well as deadlines applicable to the plan and plan administrators. The deadline extension period is determined on an individual-by-individual or case-by-case basis.

The actual date the compliance timeframe resumes will depend on the date the National Emergency is declared to be over by the Federal Government.

The timeframes for the following plan conditions are extended by this Final Rule:

- HIPAA Special Enrollment Periods (“COBRA Qualifying Events”)
- COBRA Election periods
- The date for making COBRA premium payments
- The date for qualified beneficiaries to notify the COBRA administrator of a qualifying event or a determination of disability
- The date for filing a benefits claim (including run-out claims periods under Health FSAs and HRAs, if applicable)

- The date for filing an appeal of an adverse benefit determination
- The date for requesting an external review of an adverse benefit determination
- The date for filing a corrected request for external review, in the event the initial request was incomplete.

Coverage of diagnostic testing for COVID-19

Effective Date of Material Modifications: 3/27/2020

Participants receiving testing for COVID-19 will be covered by private insurance plans or self-funded group health plans without cost sharing or prior authorization requirements, including those tests without an Emergency Use Authorization (EUA) by the FDA. This includes both in-person and telehealth visits to an urgent care center, emergency room, or other health care provider. Per Sections 3201 and 3202 of the CARES Act, there is currently no expiration to this provision.

Pricing of diagnostic testing

For COVID-19 testing covered with no cost to patients, requires an insurer to pay either the rate specified in a contract between the provider and the insurer, or, if there is no contract, a cash price posted by the provider. Per Section 3202 of the CARES Act, there is currently no expiration to this provision.

Rapid Coverage of preventative services and vaccines for coronavirus

Provides free coverage without cost-sharing of a vaccine within 15 days for COVID-19 that has in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventative Services Task Force or a recommendation from the Advisory Committee on Immunization Practices (ACIP). Per Section 3203 of the CARES Act, there is currently no expiration to this provision.

Coverage of Over-the-Counter (OTC) Diagnostic Tests for COVID-19

Effective Date of Material Modifications: 1/15/2022

Per Section 6001 of the Families First Coronavirus Relief Act (FFCRA), the Plan will cover FDA-authorized over-the-counter at-home COVID-19 diagnostic tests without any cost-sharing requirements, prior authorization, or other medical management requirements, regardless of whether ordered by a health care provider. Reimbursement will only be provided for tests purchased on or after January 15, 2022, from a pharmacy or retailer and is limited to eight (8) tests per covered person per 30-day period, unless prescribed by a health care provider. Tests purchased at in-network pharmacies will be covered with no out-of-pocket costs. Tests purchased at out-of-network pharmacies may be reimbursed up to $12 per test, provided the participant completes and submits a reimbursement form to the Plan Administrator. Tests may not be purchased for resale or to meet employer requirements, such as testing in lieu of vaccination. This requirement is currently expected to continue through the Coronavirus public health emergency period.

ARTICLE 7. Summary of Material Modification(s)

This summary of material modification ("**SMM**") describes changes to Holland Enterprises, LLC Health and Welfare Benefit Plan ("**Plan**") and supplements the Summary Plan Description ("**SPD**") for the Plan. The effective date of each of these changes is indicated below.

General Plan Information:

Plan Name: Holland Enterprises, LLC Health and Welfare Benefit Plan
Plan Number: 506
Plan Sponsor: Holland Enterprises, LLC

Summary of Material Modification(s) to Plan:

SMM - Medical Insurance Trust Removal

- Effective Date of Material Modification: 04/01/2022
- Benefit Plan(s) Impacted: Medical Insurance Trust Plan Correction, Company Legal Name Correction,
- Reason(s) for SMM: Provisions that establish new conditions or requirements
- Summary of Change(s):
    - Company Name Correction: Effective 12/31/2021, the company legal name is Holland Enterprises, LLC.
    - Medical Insurance Trust Plan Administrator Correction: This benefit is administered by the outside Trust: Fargo-Moorhead Home Builders Health Plan & Trust, not Holland Enterprises, LLC. The plan is hereby removed from the SPD/Wrap document. In addition, any reference language throughout the SPD/Wrap document is not relevant. Fargo-Moorhead Home Builders Health Plan & Trust is the Plan Sponsor and responsible for administering the plan, providing all plan documents and filing annual 5500's.