MEDICAL TRANSPORTATION MANAGEMENT, INC. SECTION 125 PLAN

SUMMARY PLAN DESCRIPTION

Amended and restated effective January 1, 2026

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MEDICAL TRANSPORTATION MANAGEMENT, INC. SECTION 125 PLAN

INTRODUCTION

The Employer has amended and restated the Medical Transportation Management, Inc. Section 125 Plan ("Plan") that was previously established for you and other eligible Employees. Under the Plan, you will be able to choose among certain benefits that the Employer make available. The benefits that you may choose are outlined in this Medical Transportation Management, Inc. Section 125 Plan Summary Plan Description ("SPD"). This SPD will also tell you about other important information concerning the amended Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of the Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under the Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this SPD carefully so that you understand the provisions of the amended and restated Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. Also, if there is a conflict between an insurance contract (or the Employer's self-funded plan) and either the Plan document or this Summary Plan Description, the insurance contract (or the Employer's self-funded plan) will control. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. The Employer may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, the Employer will notify you.

The Employer has attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other Plan representative). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About the Plan."

I
ELIGIBILITY

1. When can I become a Participant in the Plan?

Before you become a Plan member (referred to in this SPD as a "Participant"), you must meet the eligibility requirements described below. After meeting the eligibility requirements:

(a) Premium Benefits. You will automatically become a Participant in the Plan if you elect coverage under the premium benefits (unless, as described below, you affirmatively elect not to participate in the Plan).

(b) Flexible Spending Account Benefits. You will be required to make an election, in the form and manner required by the Plan Administrator, before you can enroll in the Health Flexible Spending Account, the Limited Health Flexible Spending Account, and the Dependent Care Flexible Spending Account. Later in this SPD, except as where specifically differentiated, any references to Health Flexible Spending Accounts will also include Limited Health Flexible Spending Accounts, where applicable.

(c) Health Savings Account Benefits. You will also be required to make an election, in the form and manner required by the Plan Administrator, before you can enroll in the Health Savings Account.

2. What are the eligibility and entry requirements for the Employer's Plan?

An employee of the Employer ("Employee") is eligible to participate in the Plan if the following requirements are satisfied:

You will be eligible to participate in (i) the medical premium and Health Savings Account benefits if you are regularly scheduled to work at least 30 hours per week, and (ii) all other benefits if you were regularly scheduled to work at least 40 hours per week. The foregoing notwithstanding, if you are a Hawaii Employee, you will be considered an eligible Employee for purposes of the medical premium benefit (or its successor), consistent with the eligibility requirements of the Hawaii Prepaid Health Care Act.

You will enter the Plan as follows:

<u>Salaried Employee</u>. If you are a salaried Employee, you will enter the Plan on your initial date of employment.

<u>Hourly Employee</u>. If you are an hourly Employee, you will enter the Plan on the first day of the month coinciding with or next following two months from your initial date of employment.

<u>Union Employee</u>. The foregoing notwithstanding, if you are an Employee whose employment is governed by the terms of a collective bargaining agreement between Employee representatives and the Employer (or any affiliated employer set forth in ***Appendix A***) under which benefits were the subject of good faith bargaining between the parties, you will be eligible to participate in certain benefits under the Plan and will enter the Plan as set forth in such agreement solely to the extent such agreement expressly provides for such coverage in the Plan.

<u>Hawaii Employee</u>. Regardless of whether you are an hourly or salaried Employee, if you are a Hawaii Employee, you will enter the Plan with respect to the medical premium benefit consistent with the eligibility requirements of the Hawaii Prepaid Health Care Act.

<u>Variable Hour Employee</u>. If you are (i) classified as a "Variable Employee" (i.e., regularly scheduled to work less than 30 hours per week, or a variable hour or seasonal Employee (regardless of the number of hours worked)), and (ii) are determined by the Employer to have averaged at least 30 hours per week during a measurement period, you will be eligible to become a Participant in the Plan for a medical premium benefit subject to the Patient Protection and Affordable Care Act ("PPACA") (and for any additional benefit) designated by the Employer for the immediately subsequent stability period. If, as a Variable Employee, you are determined by the Employer to be an eligible Employee for a given stability period, you will remain an eligible Employee for the entirety of such stability period, even if you are transferred during such stability

period to a position in which you will work or are expected to work less than 30 hours per week, on average, on a regular basis, as long as you remain an Employee of the Employer without a period of thirteen or more weeks during which you do not provide any hours of service to the Employer. For a new Variable Employee, the initial measurement period means the twelve month period measured from the Variable Employee's date of hire; the initial administrative period means the 31 day period beginning immediately following the initial measurement period; and the initial stability period means the twelve month period beginning immediately following the Variable Employee's administrative period. The standard "measurement period" each year is a twelve month period measured from November 1 through October 31, the standard "administrative period" each year is a 61 day period from November 1 through December 31, and the standard "stability period" each year is a twelve month period measured from January 1 through December 31; provided however that your initial measurement, administrative and stability periods will be based on your date of hire. As a Variable Employee, you will enter the Plan, with respect to the benefits for which you are eligible, on the first day of the applicable stability period following the date the Employer determines you, as a the Variable Employee, have satisfied the Plan's eligibility requirements. The Employer may, from time to time, adopt policies and procedures to implement and administer the provisions of the Plan relating to Variable Employees in a manner consistent with the PPACA ("Variable Employee Policy").

Health Savings Account. If you meet the eligibility requirements for the Health Savings Account, you will be eligible to participate in the Health Savings Account effective on the first day of the month following your enrollment in a high deductible health plan sponsored by the Employer.

The foregoing notwithstanding, the following individuals are not eligible Employees:

- A commissioned Employee.
- A leased Employee.
- An Employee who is considered a "2 percent shareholder" under the Federal tax law. A "2 percent shareholder" is treated as a "self employed individual" and therefore is not eligible to participate.
- An Employee who is a member, manager or partner of a limited liability company.

If you are an employee of an affiliated employer of the Employer set forth in ***Appendix A***, you may participate in the Plan if you satisfy all eligibility requirements under the Plan.

If you are a Union Employee whose employment is governed by the terms of a collective bargaining agreement between Employee representatives and the Employer (or any affiliated employer set forth in ***Appendix A***) under which benefits were the subject of good faith bargaining between the parties or a new Employee of the Employer (or its affiliated employers) who was acquired in an acquisition, merger or similar transaction by the Employer (or any affiliated employer) ("Acquisition"), your credited service for eligibility and entry into the Plan may be altered as determined by the Employer or as set forth in an applicable collective bargaining agreement or purchase agreement documenting an Acquisition. The Employer will timely communicate to you any change in credited service for eligibility and entry into the Plan.

If you are a Participant, terminate employment, and are rehired, you will reenter the Plan immediately on your date of rehire if rehired within 13 weeks of your date of termination and if you are not rehired within 13 weeks of your date of termination, you must again satisfy the Plan's eligibility requirements.

Of course, if you were already a Participant before this amended and restated Plan, you will remain a Participant. Any Employee who does not meet the above eligibility requirements is not eligible to participate in the Plan.

3. What must I do to enroll in the Plan?

Before you can join the Plan, you must make an election to participate in the Plan. The election includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for a portion of the benefits you have elected.

However, if you are covered under any of the premium benefits, you will automatically participate in this Plan to the extent of your premiums unless you elect not to participate in this Plan.

II
OPERATION

1. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out of pocket, taxable dollars. Also, the Employer may make additional (i) opt-out Employer Contributions or (ii) Health Savings Account Employer contributions to the Plan that will be contributed to your Health Savings Account if you participate in a high deductible health plan sponsored by the Employer and establish and maintain an associated Health Savings Account using the trustee/custodian designated by the Employer. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return. (See the Article entitled "General Information About Our Plan" for the definition of "Plan Year.")

III
CONTRIBUTIONS

1. How much of my pay may the Employer redirect?

Each year, the Employer will automatically contribute on your behalf enough of your compensation to pay for your premium benefit coverage unless you elect not to participate in the Plan with respect to such coverage. You may also elect to have us contribute on your behalf enough of your compensation to pay for any other benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year. The Employer will also contribute on your behalf enough of your compensation to pay for any Health Savings Account benefits you have elected.

2. How much will the Employer contribute each year?

Opt-out Employer Contribution.

If you are an Employee whose employment is governed by the terms of a collective bargaining agreement between Employee representatives and the Employer (or any affiliated employer set forth in ***Appendix A***) ("CBA") under which opt-out Employer contributions were the subject of good faith bargaining between the parties and opt-out of our group medical coverage, and complete a medical benefits waiver, we will distribute the amount set forth in your CBA, at the times required by your CBA. You will be notified of the amount and timing of the opt-out Employer contribution during your annual open enrollment period or as required in your CBA.

Unless provided otherwise in your CBA, to receive the opt-out Employer contributions, you must provide us with reasonable evidence, as determined in our sole discretion and at the time determined by us (but no earlier than the regular annual open enrollment period for the next Plan Year), that you and all members of your tax family are or will be enrolled in minimum essential coverage (other than coverage in the individual market, whether or not obtained through the marketplace) for the Plan Year for which the opt-out Employer contribution is to be paid. No opt-out Employer contribution will be paid to you if we know or have reason to know that you or any other member of your tax family does not have or will not have the alternative coverage.

Health Savings Account Employer Contribution. The Employer may contribute a discretionary amount to your Health Savings Account which the Employer will determine prior to the beginning of each Plan Year, but only if such Health Savings Account Employer contribution is approved by the Employer on a Plan Year by Plan Year basis. The Employer shall communicate to eligible Employees the amount and timing of any approved Employer Health Savings Account contribution prior to first day of the Plan Year to which such Health Savings Account Employer contribution applies. If you elect not to participate in a high deductible health plan sponsored by the Employer and establish and maintain an associated Health Savings Account using the trustee/custodian designated by the Employer, you will not be entitled to an Employer Health Savings Account contribution. You may not receive a cash payment of the Employer Health Savings Account contribution.

For the Plan Year beginning January 1, 2026, the Employer will make an Employer Health Savings Account contribution on your behalf if you are enrolled in a high deductible health plan sponsored by the Employer in accordance with the following:

HDHP Plan #	Employee Only	Family
004	$250	
005		$500
010		$1,800
011	$900	

The HSA Employer Contribution shall be made in equal 1/26 installments each biweekly pay period during the Plan Year. For new Participants, the biweekly HSA Employer Contribution shall be made only with respect to pay periods that begin on or after the date the Participant’s Health Savings Account is established by the trustee/custodian designated by the Employer.

3. What happens to contributions made to the Plan?

Premium Benefits. Each Plan Year, contributions will automatically be used to pay the premium expenses for the premium benefit coverage you have selected unless you elect not to participate in the Plan.

Flexible Spending Account Benefits and Health Savings Account Benefits. Before each Plan Year begins, you will select the Health Flexible Spending Account, Dependent Care Flexible Spending Account and Health Savings Account benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year. The Employer Health Savings Account contribution, if you are entitled to one, will be contributed to your Health Savings Account and you may elect to make additional contributions to your Health Savings Account.

4. When must I decide which accounts I want to use?

(a) Premium Benefits. If you are covered by any of the premium benefits offered by the Plan, you will automatically become a Participant with respect to the premium benefits unless you elect, during the election period (defined below), not to participate in the Plan.

(b) Flexible Spending Account Benefits. You are required by Federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

(c) Health Savings Account Benefits. If you fail to make a new Health Savings Account benefit election by the end of the applicable election period, you will be deemed to have elected not to participate in the Health Savings Account Benefit under the Plan and no further salary redirections will be authorized or made towards your Health Savings Account until you elect to contribute to your Health Savings Account.

5. When is the election period for the Employer's Plan?

You will make your initial election on or before your entry date. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.) If you are a new salaried Employee, you may make an election within 30 days of your date of hire, and such election shall be retroactive to your date of hire.

6. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

Marriage, divorce, death of a spouse, legal separation or annulment;

Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;

Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;

One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and

A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance (or the Employer's self-funded plan).

Any new Premium Benefit election must be allowed by the program documents of each Premium Benefit. Except as set forth below, any election must be made within 30 days of the change in status, and such election will be effective on the first day of the next month following the date of the status change, except that special enrollments in the event of birth, adoption, or placement for adoption will be effective back to the date of the birth, adoption, or placement for adoption, as long as timely notice is given to the Plan. Notwithstanding the foregoing, any coverage offered in conjunction with a change in status event that is effective retroactive to the date of the event shall be paid by the Employer on an after-tax basis outside of this Plan during such period of retroactive coverage (except for special enrollments in the event of a birth, adoption, or placement for adoption which shall be paid pre-tax, and through the Plan).

If an Employee has declined enrollment in the Plan for him or herself or his or her dependents (including a spouse) because of coverage under Medicaid or the Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

In addition, if an Employee has declined enrollment in the Plan for himself or herself or his or her dependents (including a spouse), and later becomes eligible for state assistance through a Medicaid or Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

However, with respect to the Health Savings Account, you may modify or revoke your elections without having to have a change in status.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then the Employer will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if the Employer add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and you may not change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance (or the Employer's self-funded plan) or if you decide to participate in the Health Savings Account.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

You may revoke your coverage under the employer's group health plan outside of the Employer's open enrollment period, if your employment status changes from working at least 30 hours per week to less than 30 hours. This is regardless of whether the reduction in hours has resulted in loss of eligibility. You must show intent to enroll in another health plan.

You may also revoke your or a related individual's coverage under the Employer's sponsored group health plan if you or a related individual are eligible to obtain coverage through the health exchanges.

7. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, the Employer will contribute amounts necessary to pay the premiums for the premium benefits in which you have elected to participate and for the Health Savings Account contributions you elected to have made unless you elect not to participate in the Plan for the next Plan Year.

Your Health Savings Account contributions are not limited by change in status rules applicable to other benefit accounts. You will be able to make changes in your Health Savings Account contributions by providing the applicable notice of change as required by us or the Health Savings Account trustee/custodian.

IV
BENEFITS

1. Health Flexible Spending Account and Limited Health Flexible Spending Account

The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by the Employer's group health plan and save taxes at the same time. The Health Flexible Spending Account allows you to be reimbursed by the Employer for expenses incurred by you and your dependents. However, if you participate in a Health Savings Account, you can only be reimbursed by the Employer under your Limited Health Flexible Spending Account for out of pocket dental, vision or preventive care expenses (including related drug costs) incurred by you and your dependents.

Effective for medical expenses incurred before January 1, 2020, you may be reimbursed for "over the counter" drugs only if those drugs are prescribed for you. Effective for medical expenses incurred on and after January 1, 2020, you may be reimbursed for "over the counter" drugs, regardless of whether the drug is prescribed, and menstrual care products as described in the Coronavirus Aid, Relief, and Economic Security Act.

You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long term care expenses. A list of covered expenses is available from the Administrator.

For 2026, the most you can contribute is $3,400. After 2026, the dollar limit may increase for cost of living adjustments. The minimum amount that you may contribute to the Health Flexible Spending Account each Plan Year is $100. In addition, you will be eligible to carryover amounts left in your Health Flexible Spending Account, up to $680 ("Carryover Maximum"). After 2026, the Carryover Maximum may increase for cost of living adjustments. This means that amounts you do not use during a Plan Year can be carried over to later Plan Years and used for expenses incurred in those later Plan Years.

In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. The Employer will also provide you with a debit or credit card to use to pay for medical expenses. The Administrator will provide you with further details. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status to change coverage.

Newborns' and Mothers' Health Protection Act: Group health plans 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).

Women's Health and Cancer Rights Act: This Plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to Plan limits for benefits for mastectomy related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Administrator for more information.

2. Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account enables you to pay for out of pocket, work related dependent day care cost with pre tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full time. Single Employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

(a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;

(b) An Educational Institution for pre school children. For older children, only expenses for non school care are eligible; and

(c) An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under the Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Each Plan Year, the minimum amount you may contribute to the Dependent Care Flexible Spending Account is $100. Generally, your reimbursements may not exceed the lesser of: (a) $7,500 (if you are married filing a joint return or you are head of a household) or $3,750 (if you are married filing separate returns); (b) your taxable compensation; or (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents).

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under the Plan. Ask your tax adviser which is better for you.

3. Premium Expense Account

A Premium Expense Account allows you to use tax free dollars to pay for certain premium expenses under various benefit programs that the Employer offer you. These premium expenses include:

Health care premiums under the Employer's self-funded medical plan.

Effective June 1, 2020, health care premiums under the Employer's fully-insured medical plan.

Dental care premiums under the Employer's self-funded dental plan.

Vision care premiums under the Employer's fully-insured vision plan.

Under the Plan, the Employer will establish sub accounts for you for each different type of coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any contracts providing benefits described above. Also, your coverage will end when you leave employment, are no longer eligible under the terms of any coverage, or when coverage terminates.

Any benefits to be provided by insurance (or the Employer's self-funded plan) will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance (or the Employer's self-funded plan), and (2) the insurance (or the Employer's self-funded plan) is in effect for you.

If you cover your children up to age 26 under your insurance (or the Employer's self-funded plan), you can pay for that coverage through the Plan.

4. May I direct Plan contributions to my Health Savings Account?

Yes. Any monies that you do not apply toward available other benefits can be contributed to your Health Savings Account, which enables you to pay for expenses which are not covered by the Employer's group health plans and save taxes at the same time.

To receive tax savings under this Plan and, if applicable, a Health Savings Account Employer contribution, you must establish and maintain a Health Savings Account using the trustee/custodian designated by the Employer. Please see your Administrator for further details.

V
BENEFIT PAYMENTS

1. When will I receive payments from my accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. The provisions of the insurance contracts (or the Employer's self-funded plan) will control what benefits will be paid and when. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

2. What happens if I don't spend all Plan contributions during the Plan Year?

Any monies left at the end of the Plan Year will be forfeited, except for: (a) the Carryover Maximum that can be carried over into the next Plan Year for the Health Flexible Spending Account; and (b) amounts contributed to your Health Savings Account.

Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. For the Health Flexible Spending Account and the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year.

Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

3. Benefits and Elections During Leave Of Absence

If you take an unpaid leave of absence you may continue benefits during the leave. In addition, if you take leave under the Family and Medical Leave Act (FMLA), you may continue, revoke or change your existing group health plan elections under this Plan in a manner consistent with the Employer's leave policy. If you continue participation during an unpaid leave of absence, you must pay an amount equal to the amount of money that you would have been required to pay had you not taken such leave, unless provided otherwise in your CBA.

If you are covered by any of the premium benefits or Health Flexible Spending Account benefits offered by the Plan and you take an unpaid leave of absence, you will be directly billed for an amount equal to the amount of money that you would have been required to pay had you not taken such leave, unless provided otherwise in your CBA. Billing will begin 30 days after the first day of the leave of absence.

Coverage under the Plan will cease if a premium payment is more than 30 days late, but you will be notified at least 15 days before coverage lapses. For both FMLA and non-FMLA unpaid leave, if your benefits coverage ceases while on unpaid leave, then you will be reinstated in the Plan upon return from such leave with the same elections as when you were participating in the Plan prior to the leave (i.e., you will not be able to make any new elections). Upon returning from leave, if you remain enrolled in benefits under the Plan, the Employer will deduct an additional 50% of your salary redirection until the full amount of the premiums accrued during the first 30 days (and any premiums that may have accrued prior to the leave) are recovered. Upon returning from leave, if the Participant does not remain enrolled in Benefits under the Plan, the Employer will deduct a flat dollar amount from your compensation each pay period until the full amount of the premiums accrued during the first 30 days (and any premiums that may have accrued prior to that leave) are recovered as follows: (a) $100 for medical premium benefits; and (b) $50 for all other benefits.

Subject to the terms above, to the extent the Employer has advanced any amount of your premiums while you are on leave, if you are a resident of the state of California, are covered by any of the premium benefits or Health Flexible Spending Account benefits offered by the Plan and take an unpaid leave of absence, the Employer will negotiate with you in good faith to establish a repayment plan for any amounts advanced by the Employer. If you do not return to work after your leave of absence, where state law allows, the Employer will deduct the amount of any amounts advanced from your accrued PTO. If no PTO is available, the Employer will collect the amount advanced in accordance with the Employer's normal election procedures.

For more information about your rights and obligations when on an unpaid leave, please contact Human Resources.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. Such USERRA continuation coverage will run concurrent with COBRA continuation coverage. If you may be affected by this law, ask your Administrator for further details.

5. What happens if I terminate employment?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

(a) You will remain covered by insurance (or the Employer's self-funded plan), but only for the period for which premiums have been paid prior to your termination of employment.

(b) You will still be able to request reimbursement for qualifying dependent care expenses incurred prior to your date of termination from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection and contributions will be made on your behalf after you terminate. You must generally submit claims within 90 days after termination.

(c) Your Health Savings Account amounts will remain yours even after your termination of employment.

(d) For health benefit coverage and Health Flexible Spending Account coverage on termination of employment, please see the Article entitled "Continuation Coverage Rights Under COBRA." Upon your termination of employment, your participation in the Health Flexible Spending Account will cease, and no further salary redirection and contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the Health Flexible Spending Account have already been made. Your further participation will be governed by "Continuation Coverage Rights Under COBRA."

6. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive tax free benefits under the Employer's Plan, it reduces the amount of contributions that you make to the

Federal Social Security system as well as the Employer's contribution to Social Security on your behalf.

VI
HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do limitations apply to highly compensated Employees?

Under the Internal Revenue Code, highly compensated Employees and key Employees generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated Employee or a key Employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key Employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under the Plan.

Plan experience will dictate whether contribution limitations on highly compensated Employees or key Employees will apply. You will be notified of these limitations if you are affected.

VII
PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

1. General Plan Information

Medical Transportation Management, Inc. Section 125 Plan is the name of the Plan.

The Health Flexible Spending Account is included under plan number 512 entitled Medical Transportation Management, Inc. Benefits Wrap Plan.

The provisions of your amended Plan become effective on January 1, 2026. Your Plan was originally effective on July 1, 2015.

Your Plan's records are maintained on a twelve month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

2. Employer Information

Your Employer's name, address, and identification number are:

Medical Transportation Management, Inc.
16 Hawk Ridge Dr.
Lake St. Louis, MO 63367
43-1719762

Employees of the affiliated employers of the Employer described in ***Appendix A*** are specifically included as Employees hereunder.

3. Plan's Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

Medical Transportation Management, Inc.
16 Hawk Ridge Dr.
Lake St. Louis, MO 63367
(888) 828-1316

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

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Medical Transportation Management, Inc.
Kerri Mileski, CHRO, or successor in office
16 Hawk Ridge Dr.
Lake St. Louis, MO 63367

You may also serve legal process on the Administrator.

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for flexible spending account expenses should be submitted to:

Inspira Financial
P.O. Box 8369
Omaha, NE 68108-0396

IX
ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

Plan Participants, eligible Employees and all other Employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. For those benefits subject to ERISA, these laws provide that Participants, eligible Employees and all other Employees are entitled to:

(a) examine, without charge, at the Administrator's office, all Plan documents, including insurance contracts (or the Employer's self-funded plan), collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration;

(b) obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies;

(c) continue health coverage for you, your spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage; and

(d) review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation rights.

In addition to creating your rights as a Participant, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

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

If your claim for a 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.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

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

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if you need assistance in obtaining documents from the Administrator, you should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

2. Claims Process

You should submit all reimbursement claims during the Plan Year. For the Health Flexible Spending Account and the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. If you terminate employment during the Plan Year, you must submit your Health Flexible Spending Account and the Dependent Care Flexible Spending Account claims within 90 days after your termination of employment. Any claims submitted after that time will not be considered.

Claims that are insured or self-funded will be handled in accordance with procedures contained in the insurance policies or contracts (or the Employer's self-funded plan). All other general requests should be directed to the Administrator of the Plan. If a dependent care claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate Plan provisions. Decisions of the Administrator are conclusive and binding.

In the case of a claim for medical expenses under the Health Flexible Spending Account, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the claim:	
Notification to You	15 days
Response by You	45 days
Review of claim denial	60 days

The Administrator will provide written or electronic notification of any claim denial. The notice will state:

(a) The specific reason or reasons for the denial;

(b) Reference to the specific Plan provisions on which the denial was based;

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

(d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review;

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

(f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 60 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

(a) was relied upon in making the claim determination;

(g) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(h) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(i) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

3. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for your child. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Administrator.

X
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform you and other Participants and beneficiaries, in summary fashion, of your rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Administrator or its designee to you if you become a Qualified Beneficiary under COBRA. While the Plan itself is not a group health plan, it does provide health benefits. Whenever "Plan" is used in this section, it means any of the health benefits under this Plan including the Health Flexible Spending Account.

1. What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to you and your eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active Employees who have not experienced a Qualifying

Event (in other words, similarly situated non COBRA beneficiaries). When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Are there other coverage options? There may be other options available when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace ("Marketplace"), which coverage began effective January 1, 2014. 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. Please note that certain excepted benefits such as health flexible spending accounts, integrated health reimbursement arrangements, or standalone vision or dental plans will not be offered under the Marketplace. For more information about health insurance options available through the Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

2. Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

(a) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(b) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. Although your domestic partner is not a Qualified Beneficiary under COBRA, the Plan may provide continuation coverage to your domestic partner only as required by any applicable state insurance laws (including the laws of the state of California and Oregon) with respect to insured premium benefits.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

3. What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that you would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(a) The death of a covered Employee.

(b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(c) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(d) A covered Employee's entitlement to any part of Medicare.

(e) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

4. What factors should be considered when determining to elect COBRA continuation coverage?

When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums**: This Plan can charge up to 102% of total Plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks**: If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

- **Drug Formularies**: For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments**: If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Medicare Eligibility**: You should be aware of how COBRA coverage coordinates with Medicare eligibility. If you are eligible for Medicare at the time of the Qualifying Event, or if you will become eligible soon after the Qualifying Event, you should know that you have 8 months to enroll in Medicare after your employment –related health coverage ends. Electing COBRA coverage does not extend this 8-month period. For more information, see medicare.gov/sign-up-change-plan.

- **Service Areas**: If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing**: In addition to premiums or contributions for health coverage, the Plan requires y to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries 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 www.healthcare.gov.

5. What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

6. What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as amended ("Trade Act"), and the Employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Administrator or its designee for further information. More information about the Trade Act is also available at www.doleta.gov/tradeact.

The Trade Act also created a tax credit for certain TAA-eligible individuals and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of a significant portion of the premiums for qualified health insurance, including continuation coverage. Effective January 1, 2016, individual coverage purchased through the Marketplace is excluded from the list of qualified health insurance. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282.

7. Is a covered Employee or Qualified Beneficiary responsible for informing the Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Administrator) will notify the Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(a) the end of employment or reduction of hours of employment,

(b) death of the Employee,

(c) commencement of a proceeding in bankruptcy with respect to the Employer, or

(d) entitlement of the Employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Administrator or its designee during the 60 day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand deliver your notice to the person, department or firm listed below, at the following address:

Inspira Financial
Benefit Billing Department
P.O. Box 953374
St. Louis, MO 63195-3374

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, you may be required to provide **a copy of the divorce decree, the legal separation agreement** or other relevant documentation as required by the Administrator.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Administrator or its designee receives *timely 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 for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60 day election period described above, the right to elect continuation coverage will be lost.

8. Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Administrator or its designee, as applicable.

9. Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

10. When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(a) The last day of the applicable maximum coverage period.

(b) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(c) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.

(d) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(e) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(1) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

11. What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(a) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(b) In the case of a covered Employee's entitlement to Medicare before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(1) 36 months after the date the covered Employee becomes entitled to Medicare. This extension does not apply to the covered Employee; or

(2) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(c) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(d) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

12. Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18 month or 29 month maximum coverage period is followed, within that 18 or 29 month period, by a second Qualifying Event that gives rise to a 36 months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Administrator or its designee in accordance with the procedures above.

13. How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18 month maximum coverage. This notice must be sent to the Administrator or its designee in accordance with the procedures above.

14. Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

15. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

16. What is Timely Payment for COBRA continuation coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

17. Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

18. How is my participation in the Health Flexible Spending Account affected?

COBRA continuation coverage under the Health Flexible Spending Account will be offered only to Qualified Beneficiaries losing coverage who have underspent accounts. A Qualified Beneficiary has an underspent account if the annual limit elected by the covered Employee, reduced by reimbursements up to the time of the Qualifying Event, is equal to or more than the cost of the Health Flexible Spending Account COBRA continuation coverage that will be charged for the remainder of the Plan Year. COBRA continuation coverage will consist of the Health Flexible Spending Account coverage in force at the time of the Qualifying Event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the Qualifying Event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan Year, and COBRA continuation coverage will terminate at the end of the Plan Year. For example, if you elected to contribute an annual amount of $500 and, at the time you terminate employment, you have contributed $300 but only claimed $150, you may elect to continue coverage under the Health Flexible Spending Account. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the $500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after tax basis. The Plan can also charge you an extra amount (as explained above for other health benefits) to provide this benefit. Unless otherwise elected, all Qualified Beneficiaries who were covered under the Health Flexible Spending Account will be covered together for Health Flexible Spending Account COBRA continuation coverage. However, each beneficiary has separate election rights, and each could alternatively elect separate COBRA continuation coverage to cover that beneficiary only, with a separate Health Flexible Spending Account annual limit and a separate premium. If you are interested in this alternative, contact the Administrator for more information.

19. Is State COBRA coverage available?

With respect to benefits under an insured group health benefit under this Plan which are subject to state continuation coverage laws, you (or your covered dependent) may be able to continue coverage beyond the eighteen (18) months of continuation coverage allowable under federal COBRA laws but only if you (or your covered dependent) meet certain eligibility, notice or residency requirements, if applicable, or any other requirements set forth by such state continuation coverage law. Specifically, and without excluding any other applicable state laws:

- California. If you receive eighteen (18) months of continuation coverage under federal COBRA laws and are a resident of the State of California, you may be able to continue coverage for up to an additional eighteen (18) months through California COBRA, known as "Cal-COBRA"; provided, however, that this right shall only apply to insured medical benefits and only to the extent required by Cal-COBRA.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Administrator or its designee. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, PPACA, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-

3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Administrator or its designee.

XI
SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of the Employer's continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

APPENDIX A
AFFILIATED EMPLOYERS

Employees of the following affiliated employers are considered "Employees" for purposes of eligibility to participate in the Plan.

MTM Transit, LLC
16 Hawk Ridge Dr.
Lake St. Louis, MO 63367
26-3937729

AAA Cab Service, Inc. (Effective 7/27/23)
4525 E. University
Phoenix, AZ 85034
86-0593914

This ***Appendix A*** is effective on and after: **January 1, 2026.**